Your Guide to NHP Coverage under the

Group Insurance Commission

Neighborhood Health Plan
Getting better together.

Member Handbook

Issued and Effective July 1, 2004

Commonwealth of Massachusetts
Group Insurance Commission

Welcome to Neighborhood Health Plan

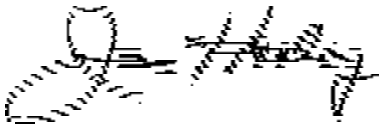
We are pleased to have you as a member.

This document describes your benefits as an NHP member. It contains some technical terms, as well as your responsibilities, and ours, in making sure you receive the most from your coverage.

If you need help understanding any part of this document, contact a Member Services representative at 1-800-462-5449 (TTY 1-800-655-1761). We're here to help you Monday through Friday from 8:30 AM to 6:00 PM.

Neighborhood Health Plan

Getting better together.



James Hooley
President and Chief Executive Officer

Paul Mendis, MD
Chief Medical Officer

Translation Services

NHP Member Services staff speak several languages. In addition, NHP will provide Members, upon request, interpreter and translation services related to administrative procedures. Please call NHP Member Services at 1-800-462-5449 or TTY 1-800-655-1761 for help.

Las personas que trabajan en el Departamento de Servicios para Miembros hablan varios idiomas. Además, NHP le ofrece, si usted así lo desea, servicios de intérprete y traducción en el área de servicios administrativos. Para ayuda o información, por favor llame al Departamento de Servicios para Miembros de NHP, por el teléfono 1-800-462-5449, TTY 1-800-655-1761.

Le personnel du service membres NHP parle plusieurs langues. De plus, NHP fournira aux membres, sur simple demande, des services d'interprétation et de traduction en rapport avec les procédures administratives. Veuillez contacter NHP Member Services au 1-800-462-5449, TTY 1-800-655-1761 pour assistance.

Fonksyonè nan depatman sèvis kliyan NHP yo pale plizyè lang. Apadesa, depi manmb yo mande, NHP ap bay manmb yo entèprèt ak sèvis tradiksyon pou sèvis ki gen rapò ak kòman konpayi an fè zafè li. Tanpri rele NHP Member Services nan 1-800-462-5449, 1-800-655-1761 pou èd.

Os funcionários do departamento de serviços para os asociados falam varias línguas. Além disso, NHP irá providenciar para seus asociados, quando solicidado, serviços de interpretação e tradução para procedimentos administrativos. Por favor ligue para NHP Member Services no número 1-800-462-5449, TTY 1-800-655-1761 para obter ajuda.

Gli incaricati di NHP per il servizio ai membri parlano molte lingue. In aggiunto, NHP puo' provvedere ai suoi membri su richiesta servizio di interprete e di traduzione per le pratiche relative a procedure amministrative. Vi preghiamo di contattare il servizio per i membri di NHP al numero 1-800-462-5449, 1-800-655-1761 per informazioni ed aiuto.

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تتكلم هيئة خدمات الأعضاء التابعة لـ NHP عدة لغات. بالاضافة، ستوفر NHP
للأعضاء، عند الطلب، خدمات الترجمة الشفهية والخطية بما يتعلق بالاجراءات
الادارية. يرجى الاتصال بـ NHP Member Services على الرقم 1-800-462-5449
للحصول على المساعدة.

NHP會員服務部的職員能講數種語言，NHP還能應會員的要求提供與行政程序有關的傳譯和翻譯服務。欲獲得有關幫助，請致電NHP Member Services：1-800-462-5449。

Inside Your Handbook

Inside Your Handbook

F. Your NHP Benefits

G. Covered Health Care Services

Inside Your Handbook

Inside Your Handbook

Inside Your Handbook

A. Welcome to NHP

Welcome to Neighborhood Health Plan (NHP). We are pleased to have you as a Member and look forward to working with you and your doctor to keep you healthy. NHP provides health care coverage to Members who reside in certain areas of Massachusetts (see NHP Service Area in the glossary section of this Handbook for more information). This Member Handbook is an important document; it explains:

- **The Services and Programs Offered by NHP;**
- **How to Choose a Primary Care Provider;**
- **Your Covered Health Care Services;**
- **What to Do in an Emergency;**
- **Your Coverage Away from Home;**
- **What to Do If You Have a Problem or Complaint;**
- **Your Rights and Responsibilities as an NHP Member.**

There is no pre-existing condition limitation or exclusion under this benefit plan. This Member Handbook and the Benefit Summary comprise the legal agreement setting the terms of your NHP Coverage. You must notify the Group Insurance Commission (GIC) and NHP of any changes in your status. Any time your name, home address, telephone number, marital status, or number of Dependents changes, be sure to call the NHP Member Services department at 1-800-462-5449 (TTY 1-800-655-1761). Also, please inform your GIC Coordinator at your work site.

If you have questions or concerns, NHP Member Services representatives are available to help you Monday through Friday from 8:30 A.M. to 6:00 P.M.

Important Address and Phone Numbers

Neighborhood Health Plan	*Phone Numbers*
Member Services Department	617-462-5449
253 Summer Street	617-772-5565
Boston, MA 02110-1120	TTY 1-800-655-1761

For more information, visit us on the web at nhp.org

B. How to Use This Handbook

Why this Member Handbook is Important

This Member Handbook explains your health care benefits and how Neighborhood Health Plan (NHP) works. It details your Covered Health Care Services and how to obtain coverage. It also explains what you can expect from NHP. This Member Handbook and Benefit Summary in your Member kit make up the NHP Evidence of Coverage, a legal document that sets the terms of your NHP Coverage. Please read the entire Evidence of Coverage and keep it for future reference.

Your NHP Evidence of Coverage

This Member Handbook and Benefit Summary constitute your complete Evidence of Coverage. NHP will issue and deliver to at least one adult Insured in each household residing in Massachusetts, upon Enrollment, a Member Handbook. NHP will also provide to the GIC, prior notice of material modifications in Covered Health Care Services under the health plan at least 60 days before the Effective Date of the modification. Unless required by law, such modifications will be made only with the agreement of the GIC.

NHP will provide notice of such material changes by issuing riders, amendments or endorsements to Insureds. In addition, NHP will issue to at least one adult Insured in each household, a revised Evidence of Coverage every five years.

Words with Special Meaning

Some words in this Member Handbook have special meaning. These words will be capitalized throughout the Handbook and defined in the glossary at the end of the Handbook. For the purposes of this Handbook, a "Member" is any individual enrolled in NHP and covered by the Subscriber Agreement for the GIC. Members are also referred to as "you" throughout this document.

NHP Provider Directories

At time of enrollment, NHP makes available a Provider Directory to new Members. NHP also provides directories to prospective or current Members upon request. To request a copy of any of the Provider Directories, call the Member Services department at 1-800-462-5449, TTY 1-800-655-1761, or visit our website at www.nhp.org for the most up-to-date listing of Providers.

- **Primary Care Directory**
  (Primary Care Sites, Primary Care Providers, and Hospitals)
- **Specialist Directory**
  (NHP-affiliated Specialists)
- **Behavioral Health Directory**
  (Mental Health and Substance Abuse Care Providers)

B. How to Use This Handbook

About Neighborhood Health Plan

Neighborhood Health Plan (NHP) is a Massachusetts-based not-for-profit Health Maintenance Organization (HMO). Founded in 1986 by the Massachusetts League of Community Health Centers and the Greater Boston Forum for Health Action, NHP's mission is to provide accessible health care systems that are Member-focused, quality-driven, and culturally responsive to Members' needs. Working in partnership with community health centers and other community-responsive Providers, NHP maintains a comprehensive Provider Network of Primary Care Providers, Specialists, Hospitals, and ancillary providers within its Service Area.

Members of NHP are eligible to receive the Covered Health Care Services described in this Handbook.

C. How NHP Works

How to Get Medical Care

You may obtain care at any NHP Network Primary Care Site or NHP Participating Provider. Your Primary Care Provider can help coordinate your preventive health care needs and any specialty or other care that you may need. Be sure to show your NHP Member Identification Card (Member ID Card) whenever you receive care. For more information on NHP's Providers, call Member Services at, 1-800-462-5449 (TTY 1-800-655-1761) or refer to your NHP Primary Care Directory. Copies of Provider Directories are available by calling NHP's Member Services Department at one of the numbers above. You can also find an up-to-date listing of providers at our website.

Your NHP Member Identification (ID) Card

Each Member of Neighborhood Health Plan receives an NHP Member Identification Card. The ID Card contains important information about you and your Covered Benefits. It also identifies you as a Member of NHP to health care Providers. You must show your ID Card whenever you receive health care. Please read your ID Card carefully to make sure all the information is correct. If you have problems with your ID Card, if you need to change or update the information on your ID card, or if you lose your ID card, call Member Services at 1-800-462-5449 (TTY 1-800-655-1761).

Your Primary Care Provider

Members must choose a Primary Care Provider upon Enrollment in NHP. Your Primary Care Provider provides or arranges most of your health care except in those cases noted on page 7 in this Handbook (see "Specialty Care Not Requiring a Referral," and "Emergency Services"). NHP Primary Care Providers practice at over 250 Primary Care Sites, including community health centers, Hospital-based group practices, multi-specialty group practices, and school-based clinics. To choose a Primary Care Provider or Primary Care Site, call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761). Please note that all Providers listed in any of the NHP Provider Directories were available to NHP Members at the time the directories were printed.

You should choose a Primary Care Site close to your home or workplace. Each family Member covered by NHP may choose a different Primary Care Provider and/or Primary Care Site. If you do not choose a Primary Care Provider or Primary Care Site within fifteen (15) days of your Enrollment date, NHP may assign you a Primary Care Provider. NHP may also assign a Primary Care Provider to you if your first choice is not available. You may change your Primary Care Provider at any time by calling the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761).

If you would like a copy of the *NHP Primary Care Directory*, which contains important information about Primary Care Sites, Primary Care Providers, and Hospitals, call Member Services at 1-800-462-5449 (TTY 1-800-655-1761).

C. How NHP Works

Changing Your Primary Care Provider

Your Primary Care Provider can provide better care when he or she knows you and your medical history. For this reason, NHP encourages you to have an ongoing relationship with your Primary Care Provider. If you need to change your Primary Care Provider, you may do so at any time, for any reason. To change your Primary Care Provider, call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761). A Member Services representative will assist you with your selection and process the change. If you choose a new Primary Care Provider at the same Primary Care Site, the change will be effective the next business day. If you choose a new Primary Care Provider at a *different* Primary Care Site, the change will be effective as of the first day of the next month.

Choosing a New Primary Care Provider

In the event that your Primary Care Provider leaves the NHP Provider Network, NHP will notify you in writing. If you receive such notification, please call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761) to select a new Primary Care Provider.

NHP will notify you at least 30 days before the disenrollment of your Primary Care Provider and will permit you to continue to be covered for Health Services, consistent with the terms of the Member Handbook, by your Primary Care Provider for at least 30 days after the he/she is disenrolled, other than disenrollment for quality-related reasons or fraud (for more information on continued coverage, see "Continued Medical Treatment" in this section).

Get to know your Primary Care Provider

If your Primary Care Provider is new to you, we suggest you make an appointment to meet him or her. To make an appointment during regular business hours, call your Primary Care Site. Explain your situation and identify yourself as an NHP Member. The Primary Care Site staff will help by answering your questions, scheduling appointments, or arranging for other needed care. If you need Urgent Care after regular business hours, call your Primary Care Site. Either your Primary Care Provider or a covering NHP Provider is available to direct your care 24 hours a day, 7 days a week. Talk to your Primary Care Provider and find out what arrangements are available for care after normal business hours. Some Primary Care Providers may have covering physicians after hours and others may have extended office or clinic hours (more information about Urgent Care is covered of this section).

All care must be provided or arranged by your Primary Care Provider to be covered by NHP. The only exceptions are listed in this section under "Specialty Care Not Requiring a Referral," and "Emergency Services." For further information, see "Care Outside the Service Area" in this Handbook.

C. How NHP Works

Hospital Care

If you need Hospital care, your Primary Care Provider will make the arrangements for your Hospital stay. You must go to the Hospital specified by your Primary Care Provider in order for NHP to cover your Hospital care.

NHP will cover Hospital care only if your Primary Care Provider or Primary Care Site arranges such care. The only exception is for Emergency care. If you change your Primary Care Provider, your new Primary Care Provider must arrange for any further Hospital care.

Specialty Care and Referrals

At times, your Primary Care Provider may want you to see a Specialist. Specialists are doctors who focus on one area of medicine. Examples of Specialists are cardiologists, dermatologists, and allergists. Some specialty services require a Referral from your Primary Care Provider. This means that your Primary Care Provider must approve your visit to a Specialist *in advance.*

Your Primary Care Provider can authorize a standing Referral for specialty Covered Health Care Services provided by a health care Provider who is participating in NHP's Network when the Primary Care Provider determines that such Referrals are appropriate, *and when:*

- **The Provider of specialty health care agrees to a treatment plan for the Member and;**
- **Provides the PCP with all necessary clinical and administrative information on a regular basis; and;**
- **The services to be provided are consistent with the terms of your NHP Subscriber Agreement.**

You must call your Primary Care Site before seeking care from a Specialist, except for services that do not require a Referral (see next page). Your Primary Care Provider will discuss the situation with you and decide if you need Specialty Care. If specialty care is Medically Necessary, your Primary Care Provider will arrange a Referral to a Specialist in the NHP Network. In most cases, NHP will cover specialty care only with a Referral from your Primary Care Provider. If a Specialist is not available in NHP's Network, your Primary Care Provider will arrange for such out-of-network care. Copayments, if any, will remain the same. NHP will arrange payment to the Out-of-Network Provider.

The Specialist will contact your Primary Care Provider in order to make decisions about any further care you may need. Sometimes a Specialist may want you to see another Provider. If so, your Primary Care Provider must obtain approval from Neighborhood Health Plan and arrange a Referral before you see any other Provider.

C. How NHP Works

Specialty Care Not Requiring a Referral

Emergency, out-of-area Urgent Care and routine Behavioral Health and Substance Abuse services do not require a Referral from your Primary Care Provider. In addition, no Referral is required for the following services:

- **Abortion, (performed in a contracted reproductive health facility)**
- **Gynecological exams (please see "Covered Health Care Services" section of this Handbook for more information about gynecological and obstetrical services)**
- **Early Intervention Services,**
- **Family Planning,**
- **Routine eye or hearing exams, and**
- **Evaluations for outpatient Physical, Occupational and Speech/Language Therapy.**

Please see your Benefit Summary for specific information about your benefits. If you have questions about needing a Referral for a service, please call the NHP Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761).

Emergency Services

An Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment of body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, placing the insured or her unborn child's physical or mental health in serious jeopardy. With respect to a pregnant woman who is having contractions, an emergency also includes having an inadequate time to effect a safe transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in the event of transfer to another hospital before delivery.

In an Emergency, go to the nearest Emergency facility, call 911, or call your local Emergency number. You are always covered for care in an Emergency. You or your representative (such as another member of your family) must call your Primary Care Site within 48 hours of any Emergency care. Notification by the attending Emergency physician to NHP or to your Primary Care Provider within 48 hours of receiving Emergency services will also satisfy this requirement. Your Primary Care Provider will arrange for any follow-up care you may need. You will not be denied coverage for medical and transportation expenses incurred as a result of any such Emergency.

C. How NHP Works

After you have been stabilized for discharge or transfer, NHP may require a Hospital Emergency department to contact a physician on-call designated by NHP or its designee for authorization of post-stabilization services to be provided. The Hospital Emergency department shall take all reasonable steps to initiate contact with NHP or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if NHP or its designee has not responded to said call within 30 minutes.

In the event the attending physician and on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of attending physician will prevail and treatment shall be considered appropriate treatment for an Emergency medical condition, provided, that such treatment is consistent with general accepted principles of professional medical practice and is a Covered Health Care Service under the policy or contract with NHP.

Urgent Care (Care Not Considered "Emergency")

Urgent Care is medical care required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life threatening and do not pose a risk of permanent damage to a Member's health. Urgent Care does not include care that is elective, Emergency, preventive or health maintenance. Examples of conditions requiring Urgent Care include but are not limited to fever, sore throat, earache, acute pain.

Care Outside the NHP Service Area

If you need Emergency Care or Urgent Care while you are temporarily outside the NHP Service Area, go to the nearest doctor or Emergency Room or call 911 (see definition of "Emergency" on preceding page). You do not have to call your Primary Care Provider before seeking Emergency or Urgent Care while outside the NHP Service Area. You or your representative must call your Primary Care Site within 48 hours of receiving care outside the Service Area. NHP will cover any Medically Necessary Services for sickness or injury outside the Service Area except the following:

- **Care you could have foreseen before leaving the NHP Service Area;**
- **Care when travel was against medical advice;**
- **Routine care;**
- **Care for childbirth or problems with pregnancy beyond the 37th week of pregnancy, or after being told that you were at risk for early delivery; and**
- **Follow-up care that can wait until your return to the NHP Service Area.**

You may be required to pay for care received outside of NHP's Service Area at the

time of service. If so, you may submit a Claim to NHP at 253 Summer Street, Boston, MA 02210, for reimbursement for such charges. Please note that NHP must have your current address on file in order to correctly process Claims for care outside the NHP Service Area. See "Communicating with Neighborhood Health Plan" (Reimbursement and Claims Procedures) for further information and instructions on how to submit a Claim. You may also call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761) for assistance.

Continued Medical Treatment Upon Termination of NHP Provider

To continue care in the event a Provider becomes a non-NHP Network Provider, the Provider must adhere to the quality assurance standards of NHP and provide NHP with necessary medical information related to the care provided. In addition, the Provider will adhere to NHP's policies and procedures, including procedures regarding Referrals, obtaining prior authorizations and providing services pursuant to a treatment plan, if any, approved by the NHP. Providers, in providing continued medical treatment, will agree to accept reimbursement from NHP at rates applicable prior to notice of disenrollment as payment in full, and not to impose cost sharing with respect to the Insured in an amount that would exceed the cost sharing that could have been imposed if the Provider has not been disenrolled.

Pregnancy:
NHP will allow any Member who is in her 2nd or 3rd trimester of pregnancy and whose Provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with the Provider, consistent with the terms of the Member Handbook, for the period up to and including the Member's first postpartum visit.

Terminal Illness:
NHP will allow any Member who is terminally ill and whose Provider in connection with that illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with the Provider, consistent with the terms of the Evidence of Coverage, until the Member's death.

Change in Insurance Plan:
NHP will provide coverage for health services for a Provider who is not a participating Provider in NHP's Network for up to 30 days from the Effective Date of coverage, to a new Member if the Member's employer only offers a choice of Carriers in which the doctor is not a Participating Provider, and the doctor is providing the Member with an ongoing course of treatment or is the Member's Primary Care Provider. With respect to a Member in her 2nd or 3rd trimester of pregnancy, this provision applies to services rendered through the first postpartum visit. With respect to a Member with a terminal illness, this provision applies to services rendered until death.

If an NHP Primary Care Provider Becomes Disenrolled:
In the event that your Primary Care Provider leaves the NHP Provider Network, NHP will notify you in writing. If you receive such notification, please call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761) to select a new Primary Care Provider.

NHP will notify you at least 30 days before the disenrollment of your Primary Care Provider and will permit you to continue your coverage for Covered Health Care Services, consistent with the terms of the Subscriber Agreement, by your Primary Care Provider for at least 30 days after he/she is disenrolled, other than disenrollment for quality-related reasons or for fraud.

Physician Profiling

Physician profiling information is available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts. This information may be found at www.massmedboard.org.

Concierge Services

Early in 2002, the Division of Insurance became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients and to receive special customer service from the provider (e.g. access to the provider's cellular telephone, more personalized service). Members who use physicians who provide additional customer service for a fee (concierge service) should be advised that those concierge services are not part of NHP's health plan coverage. Members are asked to notify NHP if their provider approaches them to offer/deliver such services for additional fees. Neighborhood Health Plan does not support this practice.

Relationship of NHP to NHP Providers

NHP Providers are independent contractors. NHP's relationships with its Providers are governed by separate contracts. Providers may not change the Evidence of Coverage or create or imply any obligation for NHP. NHP is not liable for statements about this agreement made by Providers, their employees, or agents. NHP cannot guarantee the availability of individual Providers or Provider groups. NHP may change arrangements with Providers, including the addition or removal of Providers, without notice to Members. Please note that all Providers listed in any of the NHP Provider Directories were available to NHP members at the time the directories were printed.

D. GIC Benefits Summary

The following is a Summary of Benefits available to you. This list is only a summary of the Coverage provided by the plan. Be sure to read the complete explanation found in the section called "Covered Health Care Services," which describes each Member's Coverage in more detail and important information about requirements for, and any limitations of, Coverage. These benefits are covered when Medically Necessary, authorized by Neighborhood Health Plan (NHP), ordered by your Primary Care Provider (PCP), and provided by an NHP Participating Provider. The Copayments for several Outpatient Covered Health Care Services are limited during each calendar year to 15 office visits per individual Subscriber and 25 per family Subscriber. Outpatient surgery has a separate Copayment schedule of $75 per occurrence with a cap of 4 Copayments per calendar year. Inpatient Hospital admissions have a Copayment of $200 per admission with a cap of 4 Copayments per calendar year. Outpatient Behavioral Health (Mental Health and Substance Abuse Services) has a Copayment limitation during each calendar year of 15 office visits per Subscriber and 25 per family. Members should keep receipts for all visits and Copayments. Contact Member Services at 1-800-462-5449 (TTY 1-800-655-1761) about reimbursement if Copayments were made after the maximum was reached.

Coverage/Benefit	*Copayments*
Urgent and Emergency Medical Care	
Urgent Care at NHP Primary Care Site Per visit.	$15 *
Emergency Room Treatment Per visit, unless admitted to Hospital.	$50
Acute Inpatient Medical Care	
All Drugs	$0
Anesthesia	$0
ICU and CCU	$0
Nursing Care	$0
Physician Care	$0
Private Room Per admission, with a maximum of four (4) Copayments per calendar year. Private room must be determined Medically Necessary and authorized by NHP.	$200
Radiation Therapy	$0
Semi-private Room Per admission, with a maximum of four (4) Copayments per calendar year.	$200
Surgery	$0
X-rays and Lab Services	$0

D. GIC Benefits Summary

Coverage/Benefit	*Copayments*

Skilled Nursing Facility or Rehabilitation Hospital Care

Inpatient Care - Skilled Nursing Facility $0
Up to 100 days per calendar year.

Inpatient Care - Rehabilitation Hospital $200
Per admission, with a cap of four (4) Copayments per calendar year.

Maternity Care

Prenatal Care, Exams and Tests $15*
For first office visit.

Hospital and Delivery Services $200
Per admission, with a cap of four (4) Copayments per calendar year.

Newborn Care $0

Postnatal Care $15*
Per visit.

Mental Health – Substance Abuse Care

Outpatient Mental Health Care

Evaluation, Diagnosis, Treatment, Crisis Intervention, and Referral Services by a qualified psychiatric professional. ..... $15 +
Per visit.

Outpatient psychological testing ..... $15 +
Per visit.

Outpatient Alcohol – Substance Abuse Detoxification ..... $15 +
Per visit.

Inpatient Mental Health Care

Psychiatric Care (Acute Care Hospital) $0

Inpatient Care (Psychiatric Hospital) $0

Inpatient Care (Substance Abuse Treatment Facility) $0

Inpatient Alcohol and/or Substance Abuse Detox $0

Outpatient Health Care Services

Allergy Treatment $0

Cardiac Rehabilitation Program $0

Early Intervention Services $0
Up to $3,200 per calendar year per child up to age (3) three.

Eye Examinations $15*
Per visit.

Family Planning Services $15*
Per visit.

Infertility Services ..... $15 / $75 / $200
$15 Office / $75 Outpatient / $200 Inpatient.

D. GIC Benefits Summary

Coverage/Benefit	*Copayments*
Immunizations and Vaccinations	$0
Isotope, Radium, Radon, or X-ray Therapy	(see radiation therapy)
Laboratory tests, diagnostic X-ray	$0
Office Visits Per visit.	$15*
Outpatient Surgery Per service, with a cap of four (4) Copayments per calendar year.	$75
Physician Visits (home of office)	$15*
Preventive Health Care – Adult	$15*
Radiation Therapy Isotope, Radium, Radon or X-ray therapy in lieu of surgery or for malignancy.	$0
Short-term Rehabilitative Care, Occupational and Physical Therapy Up to 90 days per acute episode.	$15*
Specialty Care and Consultants	$15*
Speech Therapy	$15*
Well-child Care (including exams and tests)	$15*

Dental Care

Initial Emergency Treatment (within 72 hours of injury) Including reduction of fractures & removal of cysts or tumors; Copayment based upon place of service.	$15 / $50
Removal of seven (7) or more permanent teeth	$75 / $200
Excision of radicular cysts (involving the roots of three (3) or more teeth)	$75 / $200
Gingivectomies of two (2) or more gum quadrants	$75 / $200
Extraction of impacted teeth $75 for Surgical Day Care Services or $200 for Hospital Inpatient Care Services (limited to four (4) Copayments per calendar year).	$75 / $200

Benefits are provided for the dental services listed above only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Drugs and Over-The-Counter Medications

Prescription Drugs (30-day supply) $10 generic / $20 brand name preferred / $40 brand name non-preferred.	$10 / $20 / $40
Prescriptions By Mail Service (3-month supply) $20 generic / $40 brand name preferred / $120 brand name non-preferred.	$20 / $40 / $120
Select OTC (over-the-counter) Medicines With prescription from an NHP Provider.	$0
Select Diabetic Drugs and Supplies (30-day supply) $10 generic / $20 brand name preferred / $40 brand name non-preferred.	$10 / $20 / $40

D. GIC Benefits Summary

Coverage/Benefit	*Copayments*

Home Health Care

Skilled Nursing Visits $0

Physical Therapy $0

No charge when patient is receiving home care.

Physician House Call $15*

Durable Medical Equipment $0

No charge when patient is receiving home care.

Other Services

Prosthesis $0

Ambulance Services $0

Bone Marrow Transplant ..... $75 / $200

$75 for Surgical Day Care or $200 for Hospital Inpatient Care Services.

Medically Necessary Durable Medical Equipment ..... 20% of Cost

20% of purchase price or monthly rental cost.

Health Education Programs $0

Hearing Aids ..... $0 / 20%

No charge up to first $500; 20% of purchase price of the next $1,500.
(Maximum benefit per person per two-year period is $1,700)

Hospice $0

Human Organ Transplant ..... $75 / $200

$75 for Surgical Day Care or $200 for Hospital Inpatient Care Services.

Kidney Dialysis / Hemodialysis $0

Second Opinions $0

Orthotics (other than foot orthotics) $0

Oxygen Therapy $0

(*) Benefit per Calendar Year—Office Visits
Copayment maximum is 15 visits per individual and 25 visits per family. Benefits marked (*) count toward this Copayment cap and a single Copayment covers all covered benefits used during a single visit.

(+) Benefit per Calendar Year—Mental Health Services
Copayment maximum is 15 visits per individual and 25 visits per family.

E. Eligibility and Enrollment

Eligibility

Individuals are accepted for Enrollment and continuing Coverage only if they meet all applicable eligibility requirements as set forth below. In addition, individuals must satisfy any eligibility requirements imposed by the Group Insurance Commission. The GIC may require the Subscriber to furnish evidence satisfactory to the GIC on any family Member's eligibility, such as a marriage certificate, birth certificate, a court order for support or a divorce decree.

Subscriber Eligibility

To be eligible to enroll as a Subscriber, a person must:

1. **Be an employee of the Commonwealth of Massachusetts** entitled on his/her own behalf (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health benefit plan, OR be a retiree of the Commonwealth of Massachusetts entitled on his/her own behalf (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health benefit plan and not be enrolled in Medicare.

   To be a Subscriber to NHP, you must be an employee of the Commonwealth of Massachusetts as indicated above, in accordance with employee eligibility guidelines authorized by the GIC and NHP. This includes GIC's up-to-date payment of applicable premium for Coverage.

2. To be eligible for Coverage by NHP, you must live, and have a permanent residence in certain areas of Massachusetts (see NHP Service Area in the glossary section of this Handbook), at least nine months of a year to be eligible. The following counties or cities and towns within counties make up the NHP Service Area:

County	Area
Bristol	Acushnet, Dartmouth, Easton, Fairhaven, New Bedford
Essex	Entire county
Hampden	Entire county
Middlesex	Entire county
Norfolk	Entire County
Plymouth	Abington, Bridgewater, Brockton, East Bridgewater, Hanover, Hingham, Hull, Marshfield, Mattapoisett, Norwell, Rochester, Rockland, Scituate, West Bridgewater, and Whitman
Suffolk	Entire County
Worcester	Entire County

E. Eligibility and Enrollment

Coverage will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. This residency requirement does not apply to a Dependent Child who is enrolled as a full-time student attending an accredited educational institution. Employees who do not choose to join a health plan when first eligible must wait until the next annual enrollment period to join.

Dependent Eligibility

Please see your GIC Benefits Coordinator for specific Dependent eligibility requirements as agreed upon by the GIC and NHP.

To be eligible to enroll as a Dependent, a person must be:

1. **The employee's spouse** (wife or husband) or surviving spouse (until remarriage) or a divorced spouse who is eligible for Dependent Coverage pursuant to Massachusetts General Laws Chapter 32A; or

2. **The former spouse of the Subscriber**, until the Subscriber or the former spouse remarries or until such time as may be specified in the divorce judgment, whichever occurs first; or

3. **The child of an eligible Dependent of the Subscriber** until such time as the parent is no longer an eligible dependent as determined by the GIC.

4. **An unmarried child of the employee or the employee's spouse**, by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship, until the age of nineteen (19) years; or

5. **An unmarried child who depends upon the employee**, retiree or surviving spouse for support, lives within the NHP Service Area with such an employee, retiree or surviving spouse, and where there is evidence of a regular parent-child relationship satisfactory to the Group Insurance Commission until the age of nineteen (19) years; or

6. **An unmarried child under the age of nineteen** (19) years who is the surviving Dependent of an employee or retiree or surviving spouse until the age of nineteen (19) years or until he/she is eligible for other group Health Coverage, whichever is earlier; or

7. **An unmarried child who, upon becoming nineteen** (19) years of age, is mentally or physically incapable of earning his/her own living (self-support), as determined by the Group Insurance Commission: or

8. **An unmarried full-time student, age nineteen** (19) through age twenty-three (23) as determined by the GIC; or

9. **An unmarried full-time student, age twenty-four** (24) and older and for whom an additional premium charge is being paid; or

10. **A newborn child of the Subscriber's Dependent son or daughter** until the earlier to occur of (1) the date the parent of such child ceases to be an eligible Dependent of the covered employee or retiree or surviving spouse or (2) the date the child ceases to be a Dependent.

Residence

To be eligible for NHP Membership, all Subscribers and their Dependents, with the exception of student Dependents, must reside at least 9 months of each year within the NHP Service Area (also known as the "Service Area"). NHP's Service Area covers most all Massachusetts counties, cities and town.

County	Area
Bristol	Acushnet, Dartmouth, Easton, Fairhaven, New Bedford
Essex	Entire County
Hampden	Entire County
Middlesex	Entire County
Norfolk	Entire County
Plymouth	Abington, Bridgewater, Brockton, East Bridgewater, Hanover, Hingham, Hull, Marshfield, Mattapoisett, Norwell, Rochester, Rockland, Scituate, West Bridgewater, and Whitman
Suffolk	Entire County
Worcester	Entire County

However, because Service Areas change periodically, it is important that you check the availability of Provider in your area to verify they are part of the NHP Provider Network.

Enrollment

Persons who meet the eligibility requirements of the section titled "Eligibility" and subsections titled "Subscriber", "Dependent" and or "Residence" may enroll in NHP by submitting a completed Enrollment application to their GIC Coordinator and to NHP. An applicant is enrolled only upon acceptance of the Enrollment application by the GIC and NHP. At the time of Enrollment, each Member enrolled will be required to choose

the NHP Primary Care Provider to whom he/she must go for primary care. Members of a family may choose different NHP Primary Care Providers for their individual care. Each Member chooses or is assigned to a Primary Care Provider (PCP) who provides or arranges for a Member's Covered Services.

Effective Date

Please see your GIC Coordinator for information on Enrollment and Effective Dates of coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), individuals may enroll in NHP at any time if:

1. **The employee's spouse or eligible Dependent has lost other insurance.**
2. **The employee marries.**
3. **The employee has a newborn or adopts a child.**
4. **The employer contributions toward the Dependent's Coverage are terminated.**

For items #1, 2, and 4, the Effective Date will be determined by the GIC. For item #3, the Effective Date must be the date of birth in the case of a newborn Dependent or in the case of an adoptive Dependent, the Effective Date must be the date of adoption or placement for adoption.

New Dependents

1. New Dependents of a Subscriber with Family Coverage may be added as of the date of marriage, birth, adoption or other qualifying event if notice of the addition is sent to GIC and NHP within 60 days of the date the dependency is established, and the applicable premium has been received by GIC. If notification of the qualifying event is not received within 60 days, then the Effective Date is determined by the GIC.

2. New Dependents of a Subscriber with Individual Coverage, including newborn children, will be covered as Dependents only if the Subscriber obtains Family Coverage within 60 days of the date dependency is established and applies for and has been approved for Family Coverage. You can apply for Family Coverage with the GIC Coordinator at your agency. A Subscriber shall not be permitted to change from individual to Family Coverage, or from Family Coverage to Individual Coverage, more than once within each contract year.

Existing Family Members

Existing eligible family Members may be added as Dependents when the Subscriber changes from Individual to Family Coverage.

E. Eligibility and Enrollment

Adoptive Dependents

A legally adopted child under the age of nineteen (19) is eligible for Enrollment from the date the child is physically placed in the custody of the home of the Subscriber or Dependent for the purpose of adoption; or if the child resided previously in the Subscriber's or Dependent's home as a foster child, from the date of the filing of the petition to adopt.

Enrollment While Hospitalized

If a covered person is hospitalized on the date that his/her coverage takes effect, coverage shall be provided by the Plan as of that date; however, the covered person, if physically capable, must notify the Plan within 48 hours of the date his/her Coverage takes effect, and, following notification, must comply with the Plan's instructions with respect to further care.

Student Dependent Coverage

When your Dependent child goes to school away from home, he or she is still covered by NHP. NHP Coverage works one of two ways for student Dependents, depending on where they go to school.

Students Inside the NHP Service (Enrollment) Area

If your Dependent child goes to school inside the NHP Service Area, then he or she can choose an NHP Primary Care Provider near school. This Provider manages your child's care just as your Primary Care Provider does for you.

County	Area
Bristol	Acushnet, Dartmouth, Easton, Fairhaven, New Bedford
Essex	Entire County
Hampden	Entire County
Middlesex	Entire County
Norfolk	Entire County
Plymouth	Abington, Bridgewater, Brockton, East Bridgewater, Hanover, Hingham, Hull, Marshfield, Mattapoisett, Norwell, Rochester, Rockland, Scituate, West Bridgewater, and Whitman
Suffolk	Entire County
Worcester	Entire County

The NHP Service Area is where Members must live to be eligible for Enrollment. Please see the following information about student Dependents who live *outside* of the NHP Service Area. The NHP Service Area includes all the places where NHP Providers are

available to care for Members. NHP may revise the NHP Service Area from time to time. Please call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761) if you have further questions regarding the Service Area.

1. **Students Outside the NHP Service (Enrollment) Area** - If your child goes to school outside the NHP Service Area, NHP provides special Coverage. This is because there are no nearby NHP Primary Care Providers who can manage your child's care while he or she is going to school. This special Coverage allows benefits for care that could not have been foreseen before your child left the Service Area. All the rules and limits on Coverage listed in the Benefit Handbook apply to these benefits, except that your Dependent child does not need to get care through his or her Primary Care Provider. Please note that your Dependent child is entitled to all the benefits in this Agreement when he or she returns to the Service Area and receives care from NHP Providers. All benefit limits specified on the Evidence of Coverage shall apply to care outside of the NHP Service Area for student Dependents.

Eligibility for Out-of-Area Student Coverage

Coverage for students living outside the NHP Service Area is available only to a Dependent who is:

- **An unmarried child of a Subscriber or Subscriber's spouse who meets the definition of Dependent according to the Agreement between NHP and the GIC.**
- **Enrolled on a full-time basis at an accredited educational institution located outside the NHP Service Area; and**
- **Registered in advance with NHP as a student attending school outside the NHP Service Area.**
- **NHP may require reasonable evidence that a Member meets the above requirements.**

Benefits for Out-of-Area Student Coverage

For student Dependents who attend school outside the Service Area, NHP covers the following services when Medically Necessary and related to a specific illness or condition. Copayments will be applied as listed on the GIC Summary of Benefits.

Outpatient Services: NHP covers all Outpatient Services listed in this Benefit Handbook and the Summary of Benefits except the following:

- **Routine examinations and preventive care, including immunizations;**
- **Home health care, including maternity programs and house calls;**

- **Reconstructive surgery;**
- **Elective outpatient surgical procedures;**
- **Second opinions.**

Inpatient Services: NHP covers all Inpatient Services listed in this Benefit Handbook, except for elective procedures. Elective procedures are services that can be delayed until your child's return to the Service Area without permanent damage to his or her health. Call your Primary Care Provider and NHP within 48 hours of Hospitalization.

Change of Status

It is the responsibility of the Subscriber to inform NHP and his/her GIC Coordinator of all changes that affect Subscriber or Dependent eligibility, including but not limited to:

- **The birth of a child,**
- **Marriage of a Dependent,**
- **Death of Member**
- **Change in marital status**
- **Address changes, and**
- **When a Dependent is no longer enrolled in an accredited educational institution on a full-time basis.**

Please note that Neighborhood Health Plan must have your current address and telephone number on file so that we can contact you when necessary and to correctly process Claims for care outside the NHP Service Area. Subscribers should inform NHP of these changes by calling NHP at 1-800-462-5449 (TTY 1-800-656-1761).

Subscribers should also inform the Group Insurance Commission by notifying their GIC Coordinator.

F. Your NHP Benefits

Your Neighborhood Health Plan Benefits

Covered Health Care Services are the medical and behavioral health care services for which a Member is eligible under this Evidence of Coverage. Except as specifically stated in this Evidence of Coverage, only services and supplies that are Medically Necessary are provided or authorized by a Member's Primary Care Provider or Beacon Health Strategies Behavioral Health Provider, or the clinicians he or she designates, are Covered Health Services. Covered Health Care Services are comprehensive Inpatient, Outpatient and Emergency care services including:

- **Preventive services, such as immunizations; periodic health exams for adults;**
- **Well child care including vision and auditory screening;**
- **Family Planning;**
- **Nutrition counseling and health education;**
- **Pediatric care; and**
- **A minimum of 100 days in a 12-month period or 365 lifetime days of noncustodial care in a Skilled Nursing Facility; and which may include, but are not limited to, preventive care; optometric services and Behavioral Health (Mental Health and Substance Abuse) Services.**

General Coverage Requirements

The GIC (your employer) pre-pays a monthly premium on behalf of the Subscriber in accordance with its Contract with NHP. It is the responsibility of the GIC to pay this premium. Please contact your GIC Coordinator at your place of employment to obtain premium information.

To be covered by NHP, all Health Care Services and supplies must be:

- **Provided by or arranged by the Member's Primary Care Provider, except as previously described for Emergency and out-of-area Urgent Care (no Referral is required for the following Care: annual preventive gynecologic health examinations and Medically Necessary follow-up for maternity care; and acute or Emergency gynecological examinations);**
- **Medically Necessary, as determined by NHP;**
- **A Covered Health Care Service;**
- **Provided by an NHP Provider; and**
- **For an active Member of NHP.**

F. Your NHP Benefits

The benefits listed in this section are available to you under the plan design chosen by the GIC. Benefit limitations or variations and any Copayments applicable to your plan design follow the benefit descriptions below. This section will also describe Referral requirements and necessary plan approvals.

If you have questions about your NHP benefits, please call the Member Services Department at 1-800-462-5449 or TTY 1-800-655-1761.

New Requirements Regarding Genetic Testing and Privacy Protection

According to Massachusetts law, Neighborhood Health Plan is prohibited from canceling, refusing to issue or renew, or in any other way making or permitting any distinction or discrimination based upon genetic information, in the amount of payment of premium or rates charged, in the length of coverage, or in any other of the terms and conditions of your health coverage. In addition, neither NHP, nor any officers, agents or brokers, may require genetic tests or genetic information as defined in those sections as a condition of the issuance or renewal of any such coverage.

NHP is also prohibited from canceling, refusing to issue or renew, or in any way making or permitting any distinction or discrimination in the amount of payment of premium, or rates charged, in the length of coverage or in any other terms and conditions of your health coverage because:

1. **An insured person has had a suspected, alleged or confirmed exposure to the potential hazards and afflictions of diethylstilbestrol (DES); or**

2. **An insured person has been a victim of domestic abuse.**

G. Covered Health Care Services

The following are Covered Services for NHP Members.

Abortion:

$75 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $200 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per calendar year.

NHP covers abortion when services are obtained from an NHP Provider. You do not need a Referral from your Primary Care Provider for abortion services that are performed in a contracted Reproductive Health Service Facility. You may call the NHP Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761) for assistance in finding an NHP Provider. A referral from your Primary Care Provider is required for abortions performed in an acute hospital setting.

Acute Hospital Care

$200 per admission with a cap of 4 Copayments per calendar year

NHP covers acute care Hospital services when Medically Necessary. Your Primary Care Provider must arrange acute care Hospital services.

Ambulatory/Day Surgery

$75 per occurrence with a cap of 4 Copayments per calendar year

NHP covers Medically Necessary Outpatient surgical and related diagnostic and medical services. Your Primary Care Provider must arrange Ambulatory/Day Surgery services.

Blood and Blood Products

$0 Copayment

NHP covers administrative fees, supplies for administration, and self-donations for whole blood and its derivatives, including Factor 8, Factor 9 and immunoglobulin.

Blood Glucose Monitoring Strips

(Also see "Diabetic Services and Supplies")

NHP provides coverage for blood glucose monitoring strips when a Provider has issued a written order and when Medically Necessary for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes (also see Diabetic Services and Supplies in this section).

CAD Secondary Prevention Program

$0 Copayment

NHP offers a Coronary Artery Disease (CAD) Secondary Prevention Program to all NHP members enrolled through the Group Insurance Commission. Members

with documented coronary artery disease are potentially eligible for this program to help participants reduce Coronary Artery Disease risk factors through lifestyle changes. For more information on the CAD program, please contact NHP Case Management at 617-772-5500.

Cardiac Rehabilitation Coverage

$0 Copayment

NHP covers outpatient cardiac rehabilitation when Medically Necessary. Cardiac rehabilitation is defined as multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which is provided in either a Hospital or other setting which meets the standards promulgated by the Commissioner of the Department of Public Health. Your Primary Care Provider and/or NHP Treating Provider must arrange for cardiac rehabilitation.

Cosmetic Surgery – Acne-Related Services

(Also see "Reconstructive/Restorative Surgery")

No benefits for cosmetic surgery or acne-related surgical services are provided. See Reconstructive/Restorative Surgery benefit.

Clinical Trials

NHP provides coverage of patient care services furnished pursuant to qualified clinical trials intended to treat cancer to the same extent as the coverage would be provided if the care was not being provided in a qualified clinical trial. Your primary care provider or treating provider in consultation with your primary care provider must obtain prior authorization for your participation in a clinical trial. A "qualified clinical trial" must meet the following conditions to be covered by NHP:

1. **The clinical trial is intended to treat cancer in a patient who has been so diagnosed.**
2. **The clinical trial has been peer reviewed and is approved by one of the United States National Institutes of Health, a cooperative group or center of the National Institutes of Health, a qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants, the United States Food and Drug Administration pursuant to an investigational new drug exemption, the United States Departments of Defense or Veterans Affairs, or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board.**

3. **The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise.**
4. **With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.**
5. **The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.**
6. **The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.**
7. **The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.**
8. **The clinical trial does not unjustifiably duplicate existing studies.**
9. **The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.**

Cytologic Screening (Pap smears)

$0 Copayment

NHP covers an annual cytologic screening for women eighteen years and older.

Dental Services – Emergency

$15/$75/$200 Copayment

NHP covers *Emergency* dental care and oral surgery within 72 hours of an accidental injury to the mouth and natural sound teeth only when performed by a physician or oral surgeon. You do not need a Referral from your Primary Care Provider for these services. Go to the nearest Emergency facility or call 911 or the emergency phone number in your area.

Dental Services – Other

$75 Copayment for Surgical Day Care services limited to 1 Copayment per calendar year quarter and $200 Copayment for Hospital Inpatient Care limited to 1 Copayment per calendar year.

Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, gingivectomies of two or more gum grandaunts.

Note: Benefits are provided for the dental services listed only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Diabetic Services and Supplies

NHP will provide coverage for Medically Necessary services and supplies used in the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Services and supplies must be prescribed by an authorized health care professional. The following services and supplies are covered for a minimum thirty (30) day supply (with the exception of an insulin pump) within the following categories of benefits:

- **Outpatient Services:** outpatient diabetes self-management training and education, including medical nutrition therapy: *$15 Copayment*
- **Laboratory/radiological services:** lab tests and urinary profiles: *$0 Copayment*
- **Durable Medical Equipment (DME):** blood glucose monitors, voice-synthesizers for blood glucose monitors and visual magnifying aids for use by the legally blind. *20% Copayment of Purchase Price or Rental Cost*
- **Prosthetics:** therapeutic/molded shoes and shoe inserts: *20% Copayment of Purchase Price or Rental Cost*
- **Prescription drugs:** *blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, syringes, pumps and pump supplies, insulin pens, insulin and oral medications.*
- **Select Diabetic Drugs and Supplies:** 30-day supply, and when prescribed by NHP participating provider:

$10 generic – 30 day supply

$20 brand name preferred – 30 day supply

$40 brand name non-preferred – 30 day supply

Dialysis

$0 Copayment

NHP covers kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary

payor for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) NHP will pay for services only to the extent payments would exceed what would be payable by Medicare. Your Primary Care Provider must arrange dialysis services. If you are temporarily outside the Service Area, NHP covers limited dialysis services. You must make prior arrangements with your Primary Care Provider, who must obtain NHP approval for this coverage except in an Emergency.

Disposable Medical Supplies

$0 Copayment

NHP covers disposable medical supplies that are: a) necessary to meet a medical or surgical purpose, b) used to treat a specific medical condition, and c) nonreusable and disposable. Your Primary Care Provider must order disposable medical supplies.

Durable Medical Equipment (DME)

20% Copayment of Purchase Price or Rental Cost

NHP covers Durable Medical Equipment that is: a) used to fulfill a medical purpose, b) generally not useful in the absence of illness or injury, and c) can withstand repeated use over an extended period of time, and is appropriate for home use. Coverage includes but is not limited to the purchase of medical equipment, replacement parts, and repairs. Your Primary Care Provider must order Durable Medical Equipment. Equipment not covered includes exercise bicycles, physiotherapy equipment and foot orthotics except for children 15 and under with symptomatic flat feet and pronation.

Early Intervention Services

$0 Copayment

NHP covers Early Intervention services for Members under the age of three (3) when the Member meets established criteria. NHP pays up to $3,200 per child, per calendar year, up to a lifetime maximum of $9,600. Such Medically Necessary Services may be provided by early intervention Specialists who are working in early intervention programs approved by the Massachusetts Department of Public Health. You do not need a Referral from your Primary Care Provider for Early Intervention services. You may go to any NHP Early Intervention Provider for these services.

Educational/Psychological Testing and Therapy

Also See "Mental Health"

Diagnostic examinations or services requested for educational purposes or for use

in an educational or developmental program are covered only as described in "Mental Health Section, Mental-Health-Related Alcohol or Chemical Dependency Treatment."

Emergency Services

See Details Below

NHP covers all Medically Necessary Emergency services. An Emergency is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. You do not need a Referral from your Primary Care Provider for Emergency Services. Go to the nearest Emergency facility or call 911 or the emergency phone number in your area.

When a Member is admitted to a non-Plan affiliated Hospital due to an Emergency illness or accident and has received authorization to be compensated for necessary expenses, authorization to receive treatment at the non-Plan-affiliated Hospital will end when it is determined by a Plan Provider that the Member is able to travel to the nearest Plan-affiliated facility

Care you receive in an Emergency when you can't call your NHP doctor in advance: *$50 Copayment when you call your doctor within 48 hours*

Care you receive for injuries or sudden illnesses when out of the NHP Service Area: *$50 Copayment when you call your doctor within 48 hours*

Eye Care – Examinations (Vision Care)

$15 Copayment

NHP covers routine eye exams for Members once every 12 months. Routine eye exams do not require a Referral from your Primary Care Provider. Go to any NHP Network ophthalmologist or optometrist for these services. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your Primary Care Provider who will arrange a referral to an ophthalmologist (eye care specialist). There is no coverage for eyeglasses or contact lenses (except when medically necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery in which cases one pair per prescription change is covered), low vision aids (except for visual magnifying aids used by legally blind members with diabetes) or ocular prostheses.

G. Covered Health Care Services

Family Planning Services

$15 Copayment

NHP covers consultations, examinations, procedures and other medical services provided on an outpatient basis and related to the use of all FDA approved contraceptive methods including but not limited to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and Norplant. You do not need a Referral for Family Planning Services. You can obtain services from your Primary Care Provider, OB/GYN, Planned Parenthood, or any other NHP Provider who offers these services. All FDA-approved prescription contraceptive methods are covered.

Contraceptive services are covered under the same terms and conditions as for other outpatient services and prescription drugs.

Gynecologic/Obstetric Care

$15 Copayment

NHP covers Medically Necessary gynecological and obstetrical services. You are not required to obtain a Referral or prior authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's health care Provider Network:

- **Annual preventive gynecologic health examinations and Medically Necessary follow-up;**
- **Maternity care; and**
- **Acute or Emergency gynecologic examinations and resultant Medically Necessary health care services.**

Hearing Examinations

$15 Copayment

NHP covers comprehensive exams and evaluations performed by a hearing Specialist. Go to any NHP Provider for these services. You do not need a Referral.

NHP also provides coverage for the cost of a newborn hearing-screening test performed before the infant is discharged from the hospital or birthing center.

Hearing Aids

$15 Copayment

NHP covers hearing aids at no charge up to the first $500; 20% of purchase price of the next $1,500 to a maximum benefit of $1,700 per person per 2-year period.

G. Covered Health Care Services

Home Health Care

$0 Copayment

NHP covers home health care according to a physician-approved home health care plan when such care is an essential part of medical treatment and there is a defined goal. Home health care services are provided in a patient's residence by a public or private home health agency. Services include, but are not limited to, nursing and Physical Therapy; Occupational Therapy, Speech Therapy, medical social work, and nutritional consultation, the services of a home health aide and the use of Durable Medical Equipment (DME) and supplies if medical necessary.

Your Primary Care Provider or NHP Treating Provider must arrange services.

Home Infusion

$0 Copayment

NHP covers home infusion services. Your Primary Care Provider or NHP Treating Provider must arrange home infusion services.

Hormone Replacement Therapy

NHP provides coverage for hormone replacement therapy services including outpatient prescription drugs for peri- and post-menopausal women under the same terms and conditions as for other outpatient services and prescription drugs (refer to "Pharmacy" in this section for more information).

Hospice

$0 Copayment

NHP covers hospice care for terminally ill Members with a life expectancy of six (6) months or less provided such services are determined to be appropriate and authorized by the Member's Primary Care Provider and are equivalent to those services provided by a licensed hospice program regulated by the Department of Public Health.

House Calls

$15 Copayment

NHP covers house calls within the NHP Service Area when Medically Necessary. Providers include Primary Care Providers, Nurse Practitioners and physicians' assistants. Your Primary Care Provider must arrange for house calls.

Immunizations, Vaccinations

$15 Copayment

NHP covers immunizations when part of an office visit. Your Primary Care Provider must arrange for immunizations.

G. Covered Health Care Services

Infertility Treatment

$15 Office Visit Copayment; $75 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $200 Inpatient Copayment per admission with a cap of 4 Copayments per calendar year.

NHP will cover Medically Necessary expenses for the diagnosis and non-experimental treatment of infertility (the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year) to the same extent that benefits are provided for other Medically Necessary services and prescription medications.

The following procedures are covered, but not limited to:

- **Artificial Insemination (AI);**
- **In Vitro Fertilization and Embryo Placement (IVF);**
- **Gamete Intra-Fallopian Transfer (GIFT);**
- **Zygote Intrafallopian Transfer (ZIFT);**
- **Intracytoplasmic Sperm Injection (ICSI)**
- **Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any; (insurers may not limit Coverage to sperm provided by the spouse.)**
- **Assisted Hatching.**

NHP does not provide coverage for:

- **Any experimental infertility procedure;**
- **Surrogacy/gestational carrier**
- **Reversal of voluntary sterilization; or**
- **Cryopreservation of eggs.**

Institutional Extended Care

(Skilled Nursing Facility care, Rehabilitation Facility care, Chronic Hospital care): NHP covers up to 100 days per calendar year in an extended care facility, such as a skilled nursing facility, rehabilitation facility, chronic care Hospital or a combination of all of these. Such coverage is provided up to the benefit limit described on the Summary of Benefits only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting. Your Primary Care Provider must arrange institutional extended care services.

G. Covered Health Care Services

Skilled Nursing Facility or Chronic Care Hospital
$0 Copayment for up to 100 days per calendar year – Medical Benefit

Rehabilitation Facility
$200 Copayment Per Admission with a cap of 4 Copayments per calendar year – Medical Benefit

Laboratory Services

$0 Copayment

NHP covers services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of the Member.

Mammographic Examination (Mammogram)

$0 Copayment

NHP covers baseline Mammograms for women between age of thirty-five (35) and forty (40) and an annual Mammogram for women forty (40) and older.

Maternity Services – Inpatient

$200 per admission with a cap of 4 Copayments per calendar year

NHP covers inpatient maternity care provided by an attending obstetrician, pediatrician, or certified nurse midwife for a mother and newborn child for at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother and physician agree to an early discharge, Covered Health Care Services include one home visit by a registered nurse, physician, or certified midwife, and additional home visits when Medically Necessary and provided by an NHP Provider. There is no coverage for delivery outside the Service Area within 30 days of the expected delivery date, or after the Member has been told that she is at risk for early delivery. Your Primary Care Provider, obstetrician, or certified nurse midwife must arrange for services.

Maternity Services – Outpatient

$15 Copayment

NHP covers prenatal and postpartum care for Members when care is received from an NHP Provider. Services include prenatal exams; diagnostic tests; prenatal nutrition; childbirth education (NHP reimburses members up to $90 for childbirth classes for the member's first pregnancy and up to $45 for a member's refresher course); health care counseling; risk assessment; and postpartum exams. There is no coverage for obstetrical care outside the NHP Service Area within thirty (30) days of expected delivery date. Your Primary Care Provider, obstetrician, or certified nurse midwife must arrange for outpatient maternity services.

G. Covered Health Care Services

Mental Health and Substance Abuse Benefits

(See Page 42 for details)

Newborn Care

$0 Copayment

NHP covers all Medically Necessary newborn care. Your Primary Care Provider must arrange newborn care.

Non-durable Medical Equipment and Supplies

$0 Copayment

Non-Durable Medical Equipment and supplies are covered only when used in the course of diagnosis or treatment in a medical facility or in the course of authorized home care.

Nutritional Formulas

$0 Copayment

NHP provides coverage for nutritional formula in the following situations:

1. Formulas, approved by the Commissioner of the Department of Public Health, for the treatment of infants and children with specific inborn errors of metabolism of amino acids and organic acids such as phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia and methylmalonic acidemia;

2. Formulas, approved by the Commissioner of the Department of Public Health as Medically Necessary to protect the fetuses of pregnant women with phenylketonuria;

3. Formulas for the treatment of malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility, such as Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility and chronic intestinal false-obstruction;

4. Formulas for the treatment of members with an anatomic or structural problem that prevents food from reaching the stomach (e.g. esophageal cancer), or a neuromuscular problem that results in swallowing or chewing problems (e.g. muscular dystrophy);

5. Formulas for the treatment of members with a serious medical condition that either directly or indirectly impacts their ability to normally ingest regular foods and places them at substantial risk of malnutrition (e.g. cancer, AIDS, organ failure, etc.); and

6. Formulas for the treatment of pediatric members diagnosed with failure to thrive.

Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein in an amount not to exceed $2500 annually.

Obstetrical Services

(See Gynecologic/Obstetric Services)

Off-Label Use of Drugs for the Treatment of Cancer

Copayment for each prescription drug is: $10 Generic – 30 day supply; $20 brand name preferred – 30 day supply; and $40 brand name non-preferred – 30 day supply.

NHP provides coverage for use of off-label drugs in the treatment of cancer as it would for any covered prescription drug. The drug must be recognized for treatment of cancer in one of the standard reference compendia, in the medical literature, or by the Commissioner of the Department of Public Health. Your Primary Care Provider or NHP Specialist must arrange for this service.

Off-Label Use of Drugs for the Treatment of HIV/AIDS

Copayment for each prescription drug is: $10 Generic – 30 day supply; $20 brand name preferred – 30 day supply; and $40 brand name non-preferred – 30 day supply.

NHP provides coverage for use of off-label drugs in the treatment of HIV/AIDS as it would for any covered prescription drug. The drug must be recognized for treatment of HIV/AIDS in one of the standard reference compendia, in the medical literature, or by the Commissioner of the Department of Public Health. Your Primary Care Provider or NHP Specialist must arrange for this service.

Optometric/Ophthalmologic Care

(See "Eye Care")

Orthotics

$0 Copayment

NHP covers non-dental braces and other mechanical or molded devices when Medically Necessary to support or correct any defects of form or function of the human body due to surgery, disease or injury. Your Primary Care Provider must arrange these services. Orthotics/Support Devices for Feet: Support devices for the feet and corrective shoes are only covered for children fifteen (15) and under with certain medical conditions such as pronation or when prescribed by the Member's PCP and authorized by NHP.

G. Covered Health Care Services

Oxygen Therapy

$0 Copayment

NHP covers oxygen therapy for Members who have severe hypoxia as demonstrated by oxygen saturation levels. Coverage includes oxygen and equipment rental and supplies required to deliver the oxygen. Your Primary Care Provider must arrange oxygen therapy services.

Pediatric Specialty Care

$15 Copayment

NHP provides Coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in providing specialty pediatric care.

Pharmacy

Pharmacy benefits are offered under your GIC Coverage. NHP covers up to a thirty (30) day supply at one time of any covered prescription drug prescribed by an NHP Provider. Oral contraceptives and diaphragms are covered under this benefit. Some smoking deterrent drugs are also covered up to 90 days per contract year. Some drugs require prior authorization from NHP. All covered prescription medications require a prescription from your PCP or NHP Provider. Prescription quantities are limited to a 30-day supply. Generic substitution is mandatory whenever available. Be sure to show your NHP Member ID Card to the pharmacist at an NHP Participating Pharmacy.

Prescription Drugs: No more than a thirty (30) day supply of each prescription item except that up to a one hundred (100) unit dose may be dispensed to a Member for a chronic condition when prescribed by an NHP physician. Prescription refills shall not be permitted for more than a twelve (12) consecutive month period from the date of the original prescription. Following such twelve (12) month period a new prescription ordered by an NHP physician or a physician to whom a Member is referred by a NHP physician shall be required. The Copayment for each prescription drug is:

$10 Generic – 30 day supply
$20 brand name preferred – 30 day supply
$40 brand name non-preferred – 30 day supply

Mail order pharmacy benefit for maintenance drugs as described in Pharmacy Benefit by Mail brochure:

$20 Generic – 90 day supply
$40 brand name preferred – 90 day supply
$120 brand name non-preferred – 90 day supply

G. Covered Health Care Services

Over-the-Counter (OTC) Medications

$0 Copayment

Some over-the-counter medications are covered when ordered by an NHP Provider, such as generic versions of cough and cold medicines, allergy medicines, pain medications and insulin and diabetic supplies. The generic equivalents of certain products may be covered with $0 Copayment. Please refer to the NHP website at www.nhp.org or contact Member Services at 1-800-462-5449 (TTY 1-800-655-1761) for specific information on which products are covered.

Physician Services

$15 Copayment for Outpatient Medical Care and $0 Copayment for Inpatient Hospital Care.

NHP covers diagnosis, treatment, consultation, and minor surgery when provided by the Member's Primary Care Provider or when referred to a NHP Provider. Your Primary Care Provider must arrange these services.

Podiatry Services

$15 Copayment

NHP covers Medically Necessary podiatry services whether the service is performed by a physician or duly licensed podiatrist. Your Primary Care Provider must arrange podiatry services.

Preventive/Primary Care Services for Children

$15 Copayment

1. NHP will cover for the following services to the Dependent child of an Insured Member from the date of birth through age six (6):
    a. Physical examinations, history, measurement, sensory screening, neuropsychiatric evaluations and development screening, and assessment at the following intervals: *six times during the child's first year after birth, three (3) times during the next year, and annually until age six (6).*
    b. Coverage for newborn hearing screening test (see Hearing Exams).
    c. Hereditary and metabolic screening at birth: appropriate immunizations; tuberculin test, hematocrit, hemoglobin or other appropriate blood tests and urinalysis, as recommended by the physician, and lead screening pursuant to Massachusetts state law.
2. NHP covers injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth.

a. Coverage includes those special medical formulas approved by the Commissioner of the Department of Public Health, prescribed by a physician, and that are Medically Necessary to protect unborn fetuses or pregnant women with phenylketonuria.

Prosthetic Devices

$0 Copayment

NHP covers prosthetic devices, including evaluation, fabrication, and fitting. Your Primary Care Provider must arrange prosthetic device services.

Radiology

$0 Copayment

NHP covers all radiological services including X-rays, MRIs and CAT scans. Your Primary Care Provider must arrange radiology services.

Reconstructive/Restorative Surgery

$75 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $200 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per calendar year.

Reconstructive surgery is any procedure to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease. NHP covers surgery for post-mastectomy coverage including:

- **Reconstruction of the breast on which the mastectomy was performed;**
- **Surgery and reconstruction of the other breast to produce symmetrical appearance, and;**
- **Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.**

Your Primary Care Provider must arrange reconstructive / restorative surgery services.

Registered Nurse or Nurse Practitioner

$15 Copayment

NHP covers services rendered by a registered nurse, nurse Practitioner, nurse midwife or nurse anesthetist if such services are within the nurse's scope of practice. Your Primary Care Provider must arrange these services.

G. Covered Health Care Services

Rehabilitation Therapy (Physical and Occupational)

$15 Copayment

NHP covers evaluation and restorative, short-term treatment when needed to improve the ability to perform Activities of Daily Living and when there is likely to be significant improvement in the Member's level of function after illness or injury. Coverage includes Occupational Therapy and Physical Therapy up to ninety (90) days per acute episode. Initial evaluations for outpatient rehabilitation therapy do not require a Referral. Go to any NHP Provider of these services. Your Primary Care Provider must arrange all other rehabilitation therapy services, including ongoing treatment plans. Refer to your Summary of Benefits for any limitation on Physical or Occupational Therapy.

Routine Examinations

$15 Copayment

NHP covers routine physical exams (for example, well-child care, premarital exams, school and sports exams) as appropriate for Member's age and gender, as well as care when a Member is sick. Cytologic screening (Pap smears) and mammographic examinations are covered as outlined in this section. Annual routine gynecological exams do not require a Referral. You may go to any NHP provider of these services. Your Primary Care Provider must arrange all other routine examinations.

Second Opinions

$0 Copayment

NHP covers second opinions when provided by another NHP Provider. Second opinions from Out-of-Network Providers are covered only when the specific expertise requested is not available within the Network. Prior authorization from NHP is required.

Specialty Care

$15 Copayment

NHP covers specialty care when arranged by a Member's Primary Care Provider. You are not required to obtain a Referral or prior authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's health care Provider Network:

- **Annual preventive gynecologic health examinations and Medically Necessary follow-up;**
- **Maternity care; and**
- **Acute or Emergency gynecologic examinations.**

Speech, Hearing and Language Disorders

$15 Copayment

NHP provides coverage for the diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists.

Coverage is provided if services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists, regardless of whether the services are provided in a Hospital, clinic or a private office.

Coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.

Benefits provided are subject to the same terms and conditions established for any other medical condition covered under individual or group insurance policies.

Initial evaluations for outpatient speech therapy do not require a Referral. Go to any NHP Provider of these services.

Your Primary Care Provider must arrange all other speech therapy services, including ongoing treatment plans.

Transplants

$75 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per year and $200 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per year.

NHP covers transplants as follows:

- **Bone marrow transplants** are covered when provided within the NHP network and approved by NHP. Coverage includes but is not limited to Members with breast cancer that has progressed to metastatic disease, provided that the Member meets criteria established by the Department of Public Health.
- **Human organ transplants are covered.** Transplants must be non-experimental surgical procedures provided within the NHP Network and approved by the NHP Medical Director. Coverage includes donor's costs for both living and nonliving transplant donors to the extent that another insurer does not cover the charges.
- **Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients.** NHP will provide for all Members or enrollees coverage for the cost of human leukocyte antigen testing or

histocompatibility locus antigen testing that is necessary to establish such Member's or enrollee's bone marrow transplant donor suitability. The coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health. *Your Primary Care Provider must arrange all services.*

Transportation

$0 Copayment

Except in an Emergency, ambulance transportation is covered only when arranged by an NHP Provider. NHP covers such ambulance transport to the nearest Hospital that can provide the care you need. We also cover Medically Necessary transfer from one health care facility to another.

Urgent Care

$15 Copayment

Examples of conditions requiring Urgent Care include but are not limited to fever, sore throat, earache and acute pain. Your Primary Care Provider must arrange for Urgent Care. Urgent care outside the NHP Service Area is covered when you notify your Primary Care Provider within 48 hours after receiving care. Urgent Care does not include care that is provided in an emergency room or care that is elective, Emergency, preventive or health maintenance.

Vision Care

See "Eye Care"

Wigs (Scalp Hair Prosthesis for Cancer Patients)

20% Copayment

For hair loss suffered as a result of the treatment of any form of cancer or leukemia, a written statement by the treating physician that the wig is Medically Necessary is required. In addition, this benefit is

- **Subject to the same limitations and guidelines as other prostheses; and is**
- **Limited to $350 per year.**

H. Mental Health and Substance Abuse Services

Your Neighborhood Health Plan
Mental Health and Substance Abuse Services – General:

NHP provides or arranges for a range of inpatient, intermediate, and outpatient services that permit Medically Necessary and active and non-custodial treatment for mental disorders to take place in the least restrictive, clinically appropriate setting. NHP's mental health and addiction treatment benefits provide for inpatient and outpatient services based on the medical necessity for treatment and without annual or lifetime dollar or unit limitation.

Beacon Health Strategies (Beacon Health) is NHP's delegated Behavioral Health Managed Care Organization and provides a Network of clinicians and mental health and addiction treatment services within the NHP service area. To obtain mental health or substance abuse treatment, NHP Members may ask their Primary Care Provider for Referrals. You also may call Beacon Health Strategies for immediate information and assistance in locating the services you are seeking.

NHP Members can call Beacon Health at 1-800-414-2820 or TTY 1-781-994-7660

You can also find information at their web site, www.beaconhealthstrategies.com. NHP provides mental health and substance abuse services in conformance with the state requirements for mental health and substance abuse/alcoholism/chemical dependency coverage (M.G.L.c.176G, ss. 4 and 80). See sections below, including a summary of NHP's coverage of mental health and substance abuse services as required by Massachusetts' law.

NHP refers Members to services for mental health assessments and treatment. NHP also arranges for services for all Medically Necessary mental health and substance abuse care for categories listed in the current version of the Diagnostic and Statistical manual, published by the American Psychiatric Association, subject to the precertification requirements, Coverage limits and Copayments described in this Handbook.

Mental Health and Substance Abuse Services – Outpatient

NHP Members may directly seek outpatient mental health and substance abuse counseling or medication services from any clinicians in Beacon Health's statewide Network. The Network includes physicians with a specialty in psychiatry, licensed psychologists, licensed independent clinical social workers, licensed mental health clinical nurse specialists or licensed mental health counselors. Members may

directly contact providers of these services for treatment and do not need a formal Referral from their Primary Care Provider.

A Members' first eight (8) outpatient sessions, in each calendar year, including sessions for medication evaluation and prescription, require no clinical review for medical necessity. However, Providers do need to contact Beacon for authorization of additional outpatient counseling services. There is no maximum limit on the amount of outpatient counseling that Beacon may authorize.

All care approval is based on the Member's clinical need for care. Any Copayments for outpatient mental health or substance abuse services are separate from your Outpatient Medical Services copayment. Members should check their NHP Summary of Benefits for the Copayment amount. Outpatient Services must be provided by clinicians/programs in the Beacon Health Network unless an Out-of-Network clinician or therapist is approved by Beacon Health in advance of providing the service. The Copayments for several Mental Health Outpatient Services are limited during each contract year to fifteen (15) visits per individual Subscriber and twenty-five (25) visits per family Subscriber. These Copayments are shown under the GIC Benefits Summary with a plus sign (+). Members should keep receipts for all visits and Copayments. Copayments for Mental Health Outpatient Services are separate from Copayments for Medical Outpatient Services. Call Member Services at 1-800-462-5449 or 617-772-5565 or TTY 1-800-655-1761 about reimbursement if a Copayment was made after the maximum was reached.

Services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his or her license. NHP provides benefits for the diagnosis and treatment of mental disorders which are described in the most recent edition of the DSM. The amount and type of treatment provided under the NHP benefits are determined by medical necessity. No other limitations, coinsurance, copayment, deductibles or other cost-sharing may be applied toward these benefits except as are applied to covered medical services within the plan.

$15 Copayment per MH/SA visit *

Mental Health and Substance Abuse Services – Intermediate

NHP covers Medically Necessary Intermediate Mental Health and Substance Abuse services. Services include partial hospitalization; structured outpatient addiction program; psychiatric acute residential treatment program for children

and adolescents; observation/holding bed; intensive clinical management; family stabilization; community support; addiction day treatment for pregnant women; psychiatric day treatment; and residential substance abuse treatment. To obtain services, call Beacon Health Strategies at 1-800-414-2820 or TTY 617-654-0950. You may also contact your Primary Care Provider for assistance. You or your Behavioral Health Provider must obtain prior authorization from Beacon Health Strategies. All services must be provided by network providers unless otherwise authorized.

$0 Copayment per MH/SA visit

Mental Health and Substance Abuse Services – Inpatient

Services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the Department of Mental Health, in a private mental hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health.

NHP covers Members for all Medically Necessary acute inpatient mental health and Substance Abuse Services. Members seeking or requiring these services must use Hospitals and detoxification facilities in the Beacon Health Strategies Network unless authorized otherwise. Your Primary Care Clinician, Hospital Emergency Room, community Emergency psychiatric teams and the clinical staff at Beacon or at NHP can assist you in finding inpatient treatment. The inpatient facility must contact Beacon Health Strategies for authorization to provide inpatient treatment. NHP encourages its Members who require inpatient treatment to work closely with their inpatient treatment staff in arranging for continued treatment after discharge from inpatient treatment.

$0 Copayment per MH/SA visit

Biologically-based Mental Health Treatment

NHP will provide mental health benefits on a nondiscriminatory basis to Members for the diagnosis and treatment of the following biologically-based mental disorders:

schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders,

and other psychotic disorders or other biologically-based mental disorders appearing in the Diagnostic and Statistical manual (DSM) that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.

Non-Biologically-based Mental Health Treatment

NHP provides benefits on a non-discriminatory basis for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders.

Psychopharmacological and Neuropsychological Assessment Services

Psychopharmacological and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.

General Provisions Regarding Treatment for Substance Abuse

NHP Member benefits include inpatient detoxification and residential rehabilitation at a Beacon Health Network hospital or residential level without annual limit and as determined Medically Necessary by the Provider and Beacon Health Strategies. NHP covers outpatient treatment for addictions in the same manner as it covers mental health counseling.

Confidentiality of Information Regarding Mental Health Services

By law, NHP cannot require different terms and conditions for consent to disclose information regarding services for mental disorders than is required for disclosure of information for other medical conditions as a condition to receiving benefits. NHP's behavioral health vendor, Beacon Health Strategies uses only Licensed Mental Health professionals to determine if services for mental conditions are medically unnecessary. Services provided to treat mental conditions must be provided by a contracted provider within Beacon Health Strategies network.

Your MHSA Summary of Copayments

Outpatient Care Mental / Substance Abuse rehabilitation
$15 Copayment per Visit

Outpatient Substance Abuse detoxification
$15 Copayment per Visit

Inpatient Care Mental Health Care at a psychiatric Hospital
$0 Copayment per MH Admission

Inpatient Substance Abuse rehabilitation
(at Inpatient Substance Abuse Treatment Facility)
$0 Copayment per Admission

Inpatient Substance Abuse detoxification
$0 Copayment per Admission

I. Benefit Exclusions

NHP does not cover the following services or supplies:

Acupuncture

No benefits are provided for acupuncture.

Benefits From Other Sources

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. In addition, no benefits are provided if you could have received governmental benefits by applying for them on time. No benefits are provided for services which payment is required to be paid by a Workers' Compensation plan or an employer under state or federal law.

Biofeedback

No benefits are provided for biofeedback.

Blood and Related Fees

No benefits are provided for blood or blood products except as specified in this Member Handbook under "Your Neighborhood Health Plan Benefits."

Chiropractic Care

No benefits are provided for chiropractic care.

Cosmetic Services and Procedures

No benefits are provided for Cosmetic Services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a mental condition. Such as surgery to treat acne lesions or remove tattoos. Also medications for cosmetic purposes to treat hair loss or wrinkles. Reconstructive surgery is covered.

> *Note:* As required by federal law, for a member who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, benefits for reconstructive surgery include: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

I. Benefit Exclusions

Custodial Care

No benefits are provided for custodial or rest care. This is care that is furnished mainly to help a person in the activities of daily living, and does not require day-to-day attention by medically-trained persons.

Dental Care

No benefits are provided for routine dental care or dentures.

Educational Testing and Evaluations

No benefits are provided for educational services or testing, except such services covered under the Early Intervention Services and Outpatient Mental Health and Substance Abuse benefit. No benefits are provided for educational services whose intent is solely to enhance educational achievement (e.g. subject achievement testing) or to resolve problems regarding school performance.

Exams Required by a Third Party

No benefits are provided for physical, psychiatric and psychological examinations or testing required by a third party, including but not limited to employment; insurance; licensing and court-ordered or school-ordered exams and drug testing that are not Medically Necessary or are considered evaluations for work-related performance.

Experimental Services and Procedures

The benefits described in this Member Handbook are provided only when covered services are furnished in accordance with Neighborhood Health Plan's medical technology assessment guidelines. No benefits are provided for health care charges that are received for or related to care that NHP considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are three exceptions to this exclusion. As required by law, Neighborhood Health Plan does provide benefits for:

1. One or more stem cell ("bone marrow) transplants for a member who has been diagnosed with breast cancer that has spread. The member must meet the eligibility standards that have been set by the Massachusetts Department of Public Health;

2. Certain drugs used on an off-label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS and

3. Coverage of patient care services furnished pursuant to qualified clinical trials intended to treat cancer.

I. Benefit Exclusions

Eyewear/Laser Eyesight Correction

No benefits are provided for eyeglasses and contact lenses. Benefits are also not provided for eye surgery to treat conditions which can be corrected by means other than surgery. An example of eye surgery that is excluded is laser surgery, for conditions such as nearsighted vision. There is an exception to this exclusion. NHP does provide benefits for contact lenses when Medically Necessary for certain eye conditions, such as use for post-cataract surgery and the treatment of keratoconus.

Foot Care

No benefits are provided for routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is Medically Necessary due to systemic circulatory diseases (such as diabetes).

Non-Covered Providers

No benefits are provided for any service provided, arranged, or approved by a Provider other than the Member's Primary Care Provider or another NHP Provider. The only exceptions are those services specified under "Services that do not require a Referral" section in this handbook. Also Medications or supplies prescribed by Providers not authorized to provide care by NHP, except as covered outside the NHP Service Area.

Other Non-Covered Services

No benefits are provided for any service or supply that is not a described as a Covered Benefit in this Member Handbook. Including:

- **Any service or supply that is not Medically Necessary.**
- **A Provider's charge for shipping and handling or taxes.**
- **Medications, devices, treatments and procedures that have not been demonstrated to be medically effective.**
- **Routine care, including routine prenatal care, when the Member is traveling outside the NHP Service Area.**
- **Services for which there would be no charge in the absence of insurance.**
- **Special equipment needed for sports or job purposes.**
- **There is no coverage for delivery of a baby outside the NHP Service Area within thirty (30) days of the expected delivery date, or after the Member has been told that she is at risk for early delivery.**
- **Work rehabilitation.**

I. Benefit Exclusions

Personal Comfort Items

No benefits are provided for personal comfort or convenience items or services that are furnished for your personal care or for the convenience of your family. Some examples of non-covered items or services include: telephones, radios, televisions and personal care services. The following items are generally deemed convenience items.

- **Air conditions.**
- **Air purifiers.**
- **Chair lifts.**
- **Dehumidifiers.**
- **Dentures.**
- **Elevators.**
- **"Spare" or "back-up" equipment.**
- **Bath/bathing equipment such as aqua massagers and turbo jets.**
- **Whirlpool equipment generally used for soothing or comfort measures.**
- **Home type bed baths requiring installation (such as Schmidt Bed Bath or Century Bed Bath).**
- **Non-medical equipment otherwise available to the member that does not serve a primary medical purpose.**
- **Bed lifters not primarily medical in nature.**
- **Beds and mattresses, non-hospital type (e.g., Beautyrest or Craft-matic brand adjustable beds).**
- **Bed, hospital type in Full, Queen and King sizes.**
- **Cushions, pads and pillows except those described as covered.**
- **Pulse Tachometers.**

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of voluntary sterilization.

I. Benefit Exclusions

Self-Monitoring Devices

No benefits are provided for self-monitoring devises except for:

- **Blood glucose monitoring devises used by members with insulin-dependent, insulin-using, gestational or non-insulin dependent diabetes; and**
- **Certain devices that Neighborhood Health Plan decides would give a member having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.**

Transsexual Surgery

No benefits are provided for transsexual surgery and all related drugs and procedures.

J. Termination and Conversion

Voluntary Termination by the Subscriber

You may end your NHP membership with the GIC's approval. NHP must receive notification from the GIC within sixty (60) days of the date you want your Membership to end.

Termination for Loss of Eligibility

NHP may end or refuse to renew a Member's Coverage for failing to meet any of the specified eligibility requirements. The NHP Subscriber will be notified in writing if Coverage ends for loss of eligibility. You may be eligible for continued Enrollment under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" for more information.

Please note that NHP may not have current information concerning membership status. The GIC may notify NHP of Enrollment changes retroactively. As a result, the information we have may not be current—only the GIC can confirm membership status.

Membership Termination for Cause

Neighborhood Health Plan may terminate or refuse to renew a Member's coverage for the following reasons:

- **The failure by the GIC to make payments required under the contract.**
- **Providing false or misleading information on an application for Membership or misrepresentation or fraud on the part of the Member.**
- **The commission of acts of physical or verbal abuse by a Member that pose a threat to Providers, staff at Providers' offices or other Members and that are unrelated to the Member's physical or mental condition.**
- **Relocation of the Member outside NHP's Service Area.**
- **Non-renewal or cancellation of the GIC contract through which the Member receives Coverage.**

Notice of Termination of Membership for providing false information shall be effective immediately upon notice to a Member. Notice of termination of Membership for other causes will be effective fifteen (15) days after notice. Premium paid for periods after the Effective Date of termination will be refunded.

Continuation of Employer Group Coverage Required by Law

You should contact the GIC for more information if membership ends due to:

- **Loss of dependency due to age;**

- **Separation from employment or reduction of work hours;**
- **Divorce or legal separation**

Note: In the event of divorce or legal separation, a spouse may be eligible to keep coverage under the employee's membership, as determined by the GIC. This is the case only until the employee is no longer required by law to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. While the former spouse continues coverage under the employee's membership, there is no additional premium. After remarriage of the employee, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership for additional premium, as determined by the GIC..

If you lose Group coverage you may be eligible for continuation of group Coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

The following is important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA Coverage?

COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa.

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events. If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health

benefits program, you have the right to choose COBRA coverage if:

- **You lose your group health coverage because your hours of employment are reduced; or**
- **Your employment ends for reasons other than gross misconduct.**

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (these are known as "qualifying events"):

- **Your spouse dies;**
- **Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced; or**
- **You and your spouse divorce or legally separate.**

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons ("qualifying events"):

1. **The employee-parent dies;**
2. **The employee-parent's employment is terminated (for reasons other than gross misconduct) or hours of employment are reduced;**
3. **The parents divorce or legally separate; or**
4. **The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).**

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months. If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event (the insured's death or divorce) occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.

J. Termination and Conversion

Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- **The COBRA cost is not paid in full when due (see section on paying for COBRA);**
- **You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;**
- **You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);**
- **The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or**
- **Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).**

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides

you the right to purchase individual health insurance policies that do not impose pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group plan you are otherwise eligible for (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Send payments to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of

electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

1. You must inform the GIC of address changes to preserve your COBRA rights;
2. You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described herein. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
3. You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all coverage rights.
4. You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
5. You must inform the GIC within 60 days of the later of either 1) the date of any of the following, or 2) the date on which coverage would be lost because of any of the following events:
    - **The employee's job terminates or hours are reduced;**
    - **The employee or former employee dies;**
    - **The employee divorces or legally separates;**
    - **The employee or employee's former spouse remarries;**
    - **A covered child ceases to be a dependent;**
    - **The Social Security Administration (SSA) determines that the employee or a covered family member is disabled; or**
    - **The SSA determines that the employee or a covered family member is no longer disabled.**

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

J. Termination and Conversion

Non-Group Coverage

When your NHP coverage ends, you may be eligible to enroll in a non-group plan offered by NHP. The benefits and premium charges for these non-group plans may differ from your coverage provided under this contract. For more information about non-group coverage call NHP Member Services at 1-800-462-5449 (TTY 1-800-655-1761).

Members Eligible for Medicare

NHP does not offer health plans for individuals eligible for Medicare. You may contact the GIC for information about health plans for people eligible for Medicare.

When You Have Other Coverage

Coordination of Benefits

This section explains how benefits under this policy will be coordinated with other insurance benefits available to pay for health services that a Member has received. Benefits are coordinated among insurance Carriers to prevent duplicate payment for the same service. Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

Benefits under this Evidence of Coverage will be coordinated to the extent permitted by law with other plans covering health benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, Hospital indemnity benefits that exceed $100 per day, and governmental benefits. Coordination of Benefits will be based upon Massachusetts regulation for a service that is covered at least in part by any of the plans involved. Reimbursement to NHP shall not exceed the maximum allowable under the Plan.

When a Member is covered by two or more health benefit plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of the secondary plan(s) and without considering the benefits of the secondary plan(s). The benefits of the secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits. In the case of health benefit plans that contain provisions for the Coordination of Benefits, the following rules shall decide which health benefit plans are primary or secondary:

1. **Dependent/Non-Dependent**: The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.
2. **A Dependent child whose parents/guardians are not separated or divorced**: The order of benefits is determined as follows:

a. The benefits of the plan of the parent/guardian whose birthday falls earlier in a year are determined before those of the plan of the parent/guardian whose birthday falls later in that year. If both parents or guardians have the same birthday, the plan covering the parent or guardian for the longer time is considered primary.

b. When the other plan does not have the same rules of priority as those listed above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

3. **A Dependent child whose parents are separated or divorced**: Unless a court order, of which NHP has knowledge, specifies one of the parents as responsible for the Health Care Benefits of the child, the order of benefits is determined as follows:

   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child; and
   c. Finally, the plan of the parent not having custody of the child.

4. **Active/Inactive Employee**: The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

5. **Longer/shorter length of Coverage**: If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

6. **If a Member is covered by a health benefit plan that does not have provisions** governing the Coordination of Benefits between plans, that plan will be the primary plan.

Provider payment when NHP coverage is secondary

When a Member's NHP Coverage is secondary to a Member's coverage under another health benefit plan, NHP may suspend payment to a Provider of services until the Provider has properly submitted a Claim to the primary plan and the Claim has been processed and paid, in whole or in part, or denied by the primary plan. NHP may recover any payments made for services in excess of NHP's liability as the secondary plan, either before or after payment by the primary plan.

Worker's Compensation/Government Programs

If NHP has information indicating that services provided to a Member are covered

under Worker's Compensation, employer's liability or another program of similar purpose, or by a federal, state or other government agency, NHP may suspend payment for such services until a determination is made whether payment will be made by such program. If NHP provides or pays for services for an illness or injury covered under Worker's Compensation, employer's liability or another program of similar purpose, or by a federal, state or other government agency, NHP will be entitled to recovery of its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

Subrogation

Subrogation is a means by which NHP and other health plans recover expenses of services where a third party is legally responsible for a Member's injury or illness. If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which have been paid for or provided by NHP, NHP will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by NHP. NHP will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness or his/her liability Carrier. NHP will also be entitled to recover from a Member 100% of the value of services provided or paid for by NHP when a Member has been, or could be, reimbursed for the cost of care by another party. NHP's right to recover 100% of the value of services paid for or provided by NHP is not subject to reduction for a pro-rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations. NHP's right to 100% recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. The Subrogation and recovery provisions in this Benefit Handbook apply whether or not the Member recovering money is a minor. To enforce its Subrogation rights under this policy, NHP will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

J. Termination and Conversion

Member Cooperation

As a Member of NHP, you agree to cooperate with NHP in exercising its rights of Subrogation and Coordination of Benefits under the Evidence of Coverage. Such cooperation will include, but not be limited to:

- **The provision of all information and documents requested by NHP and the execution of any instruments deemed necessary by NHP to protect its rights;**
- **The prompt assignment to NHP of any monies received for services provided or paid for by NHP and the prompt notification to NHP of any instances that may give rise to NHP's rights.**

The Member further agrees to do nothing to prejudice or interfere with NHP's rights to Subrogation or COB. Failure of the Member to perform the obligations stated in this section shall render the Member liable to NHP for any expenses NHP may incur, including reasonable attorneys' fees, in enforcing its rights under this Plan. Nothing in this Member Handbook shall be construed to limit NHP's right to utilize any remedy provided by law to enforce its rights to Subrogation or Coordination of Benefits under this plan.

K. Communicating with NHP

When You Have Questions

NHP wants you to get the most from your NHP Membership. Member Services Representative can help you:

- **If you have any questions about your NHP benefits;**
- **If you need help choosing or changing your Primary Care Provider or Primary Care Site;**
- **If you receive a bill from a Provider;**
- **If you lose your NHP Member Identification Card (in addition, please call the Member Services Department:**

  if you move or get a new phone number;

  if your marital status changes;

  if you have a new baby or if you add a Dependent.

We are interested in hearing our Members' Complaints and concerns. Call the Member Services Department at 1-800-462-5449 (TTY 1-800-655-1761). Representatives are available Monday through Friday, 8:30 A.M. to 6:00 P.M.

Reimbursement and Claims Procedures

If you receive a bill from a Provider for a Covered Health Care Service, you may do the following:

- **Ask the Provider to bill NHP directly at the address listed on your Member Card, or**
- **Send the bill to:**

  Neighborhood Health Plan
  Attention: Member Services Department
  253 Summer Street, Boston, MA 02210-1120

If you would like reimbursement for a bill you paid for a Covered Health Care Service, send a copy of the bill and proper receipts to NHP at the above address. *Be sure to include the following information:*

- **The Member's full name, date of birth, and NHP Member identification number;**
- **The date the health care service was provided;**
- **A brief description of the illness or injury; or, for pharmacy items, a dated drug store receipt stating the name of the drug or medical supply, the prescription number, and the amount paid for the item.**

K. Communicating with NHP

Limits on Claims

You must send any bills or receipts to NHP within twelve (12) months of the Date of Service. NHP is not required to pay bills or reimburse you for Claims received later than twelve (12) months after the Date of Service. NHP will pay or reimburse you only for services that are Covered Health Care Services and that are obtained in accordance with NHP policies. Please see your Benefit Summary for further information. Within forty-five (45) days of receipt of your completed request for reimbursement, NHP will either issue payment to you (or the provider); notify you in writing of the reason your Claim was not paid; or notify you in writing that additional information is required before your request can be processed. If we fail to comply, NHP will pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the claim at the rate of 1.5 % per month, not to exceed 18 % per year, provided we are not investigating the claim because of suspected fraud.

L. Your NHP Member Rights, Responsibilities & Resources

As a Member of NHP, you have the right to:

- **Expect clear communication about benefits, policies, and procedures;**
- **Have your questions and concerns answered completely and courteously;**
- **Be treated with respect;**
- **Have privacy during treatment and expect confidentiality of all records and communications;**
- **Discuss treatment options with your Primary Care Provider or NHP Provider;**
- **Be included in all decisions about your health care;**
- **Change your Primary Care Provider or Primary Care Site;**
- **Access Emergency care 24 hours a day, seven days a week;**
- **Access an easy process to voice your concerns, and to expect follow-up by NHP;**
- **Appeal a decision made by NHP;**
- **Access your medical records in accordance with federal and state law;**
- **Make recommendations regarding NHP's Member rights and responsibilities.**

As a Member of NHP, you also have the responsibility to:

- **Choose a Primary Care Provider, the medical professional responsible for your care;**
- **Call your Primary Care Provider when you need health care;**
- **Tell any health care Provider that you are an NHP Member;**
- **Give complete and accurate medical information;**
- **Understand the role of your Primary Care Provider in providing your care and arranging other medical services you may need;**
- **Take part in making decisions about your health care;**
- **Follow the plans and instructions agreed on by you and your Primary Care Provider or NHP Provider;**
- **Understand your benefits – what's covered, and what's not.**
- **Call your Primary Care Provider within 48 hours of any Emergency or out-of-area treatment;**
- **Notify NHP of any changes in status such as address, telephone, marriage, additions to the family, changes in student dependent's eligibility, etc.**

L. Rights, Responsibilities, and Resources

Office of Patient Protection (OPP)

The Office of Patient Protection within the Department of Public Health is responsible for assisting consumers with questions regarding managed care and administering the process by which consumers may apply for external review for a benefit denial by a managed care organization. If you have questions about managed care or if you have exhausted the internal appeal process within NHP and want to apply for an external review, please contact the Office of Patient Protection:

1-800-436-7757 (phone)
1-617-624-5046 (fax)
www.state.ma.us/dph/bhqm (website)

Reporting Health Care Fraud

If you know of anyone trying to commit health care fraud, please call our confidential Compliance Helpline at 1-800-826-6762. You do not need to identify yourself. Examples of health care fraud include:

- **Receiving bills for health care services you never received.**
- **Individuals loaning their health insurance ID card to others for the purpose of receiving health care services or prescription drugs.**
- **Being asked to provide false or misleading health care information.**

M. Utilization Management & Quality Assurance

Utilization Review Procedures:

The mission of the Utilization Review program at NHP is to ensure the provision of the highest quality of health care to its Members. This is accomplished through a multi-disciplinary team approach to advocate the optimum standards of patient health, education, and safety. Our commitment to providing quality care is consistently integrated with our goal to promote appropriate resource utilization. The Utilization Review program promotes the continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for Members as they obtain the appropriate level and intensity of services, across the continuum of health care. The Utilization Review program continually evaluates the needs of NHP's Members and promotes enhancements and improvements to the program as well as to the care delivery system.

Adverse Determinations

Decisions made by NHP or a designated utilization review organization, to deny, reduce, modify or terminate a covered benefit due to lack of medical necessity, effectiveness or appropriateness of health care setting are considered Adverse Determinations. Written notification of Adverse Determinations will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- **Identify the specific information upon which the adverse determination was based;**
- **Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria;**
- **Specify alternative treatment options covered by NHP, if any;**
- **Reference and include applicable clinical practice guidelines and review criteria; and**
- **Notify you (or your authorized representative) of our internal grievance process and the procedures for requesting external review.**

NHP engages in prospective review, concurrent review with discharge planning and case management of Health Care Services as part of its Utilization Review Program.

Prospective Review

Decisions are made within two (2) working days of obtaining all necessary information, including any necessary evaluations and/or second opinions. Providers are notified of the decision within twenty-four (24) hours. Both providers and members are sent

written notification of prospective approvals within two (2) working days of the initial notification and within one (1) working day for prospective denials.

Concurrent Review
Decisions are made within one (1) working day of obtaining all necessary information, including any necessary evaluations and/or second opinions. Providers are notified of the decision within twenty-four (24) hours. Both providers and members are sent written notification (including number of extended days/visits, next review date, total number of days/visits approved, and date of service initiation) of concurrent approvals and denials within one (1) working day of the initial notification. Services subject to concurrent review are continued without liability to the member until the member has been notified of the decision.

Reconsideration
NHP offers a treating provider an opportunity to seek reconsideration of an Adverse Determination from a clinical peer reviewer in any case involving a prospective or concurrent review. The treating provider is informed of this opportunity within the written denial letter. The reconsideration process will occur within one working day of the provider's request and will be conducted between the Provider and an NHP clinical peer reviewer. If the reconsideration process does not reverse the Adverse Determination, the member or provider may pursue NHP's grievance process. The reconsideration process is not a prerequisite to NHP's grievance process.

Case Management
Case Management is for timely coordination of quality Health Care Services to meet an individual's specific health care needs while facilitating care across agencies and organizations (home health, skilled nursing, Hospitals are examples) and creating cost effective alternatives for catastrophic, chronically ill or injured Members on a case by case basis. Examples of circumstances where case management may be beneficial include organ transplantation, asthma, diabetes or major traumatic injury such as burns. In cases regarding behavioral health or substance abuse services, NHP has delegated Utilization Review to Beacon Health Strategies; Pharmacy to Express Scripts, Inc.; and Harvard Vanguard Medical Associates for all HVMA Members. Members can call Member Services at 1-800-462-5449 (TTY 1-800-655-1761) to determine the status or outcome of Utilization Review decisions.

Quality Assurance Program

Neighborhood Health Plan is committed to improving the health of its Members by providing the highest quality health care through the design, implementation and continuous improvement of the most appropriate and effective delivery systems. The scope of NHP's Quality Assurance Program includes:

- **Member satisfaction;**
- **Access to care and services;**
- **Continuity of care;**
- **Provider credentialing;**
- **Preventive health services;**
- **Patient safety; and**
- **Health care outcomes.**

Important Note: If you have a concern about the quality of care you have received by an NHP Network Provider or the Service provided by NHP, please contact the NHP Quality Services Department at 1-800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria:

Clinical guidelines and Utilization Review criteria at NHP are developed with input from practicing physicians in NHP's Network and in accordance with standards adopted by national accreditation organizations. NHP guidelines are evidence based, wherever possible, and are applied in a manner that considers the individual's health care needs. NHP guidelines are reviewed biennially or more often as new drugs, treatments, and technologies are adopted as generally accepted medical practice.

Evaluation of New Technology

NHP strives to ensure our Members have access to safe and effective medical care. With the rapid advancement of technology and pharmaceuticals, NHP has a process to evaluate new technology on a case-by-case basis as well as on a benefit level. Decisions to approve the use of a new technology are based on the highest benefit and lowest risk to the Member.

NHP reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment and pharmaceuticals to determine their safety and effectiveness. NHP uses information gathered from varied sources including peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external expert consultants in its evaluation efforts. Additionally, NHP may analyze market trends and legal and ethical issues in its evaluations as appropriate. Technologies are selected for review based on actual or potential demand.

The Chief Medical Officer or Medical Director are responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved through NHP's technology assessment process. In making this decision, the Chief Medical Officer or Medical Director reviews any available literature and consult with internal and external expert consultants as needed.

M. Utilization Management and Quality Assurance

New technologies are incorporated into the NHP benefit structure based upon the strength of the safety and efficacy evidence, market analysis and the relevance to the NHP membership.

Major Disasters

NHP will try to provide or arrange for services in the case of major disasters. These might include war, riot, epidemic, public Emergency, or natural disaster. Other causes include the partial or complete destruction of NHP facility(ies) or the disability of service Providers. If NHP cannot provide or arrange services due to a major disaster, NHP is not responsible for the costs or outcome of its inability.

Advance Directive

An Advance Directive is a written statement that expresses your wishes regarding health care if you are unable to do so due to an illness or injury. You need an Advance Directive to state your wish to decline, limit or receive full life-sustaining treatment should you become incapacitated, or to designate a specific individual, or Health Care Agent, to make health care decisions for you should you become unable to do so.

Health Care Agents

In Massachusetts, if you are at least 18 years old and competent, you may appoint someone as your Health Care Agent. Your Health Care Agent may be anyone who is well known to you and who is willing to make health care decisions in accordance with your wishes. You may appoint a Health Care Agent by completing a health proxy form. The completed health proxy form allows your Health Care Agent to act on your behalf only if your doctor determines in writing that you are unable to communicate your own health care decisions. You should discuss health care power of attorney with your Health Care Agent before signing the health proxy form. The health care power of attorney permits your Health Care Agent to make a broad range of health care decisions on your behalf.

Frequently Asked Questions About Advance Directives

Am I required to have an Advance Directive?

You are not required to have an Advance Directive and cannot be refused admittance to a Hospital or nursing home if you do not have one. If you have an Advance Directive, however, the Hospital or nursing home must advise you, upon admission, of any policies that would prevent staff from following the Advance Directive.

Is an Advance Directive in Massachusetts enforceable in another state?

Most states have laws recognizing Advance Directives prepared in other states.

Even in states without such laws, Advance Directives are evidence of your wishes and may be used in determining medical decisions made on your behalf.

Who should know about my Advance Directive?

You should discuss the details of your Advance Directive with family, friends, doctors, clergy, attorneys and anyone else who may be asked to make decisions. Discuss a wide range of situations, from routine treatment to life-sustaining treatment, experimental medicine, organ donation, etc. with these significant people. By discussing these matters in advance, family and friends will understand the types of decisions you would make for yourself, even though their own medical choices may be significantly different from yours.

Can I change the Advance Directive once it has been signed?

Yes. You should review the Advance Directive at least every five years or when there are significant changes in your life, such as divorce or serious illness, to make certain that your instructions are accurate and reflect your wishes.

Can I change my mind about having medical treatment withheld once I have signed the Advance Directive?

Yes. The Advance Directive is designed to give you more control over your medical treatment, not less. If you are well enough to communicate treatment decisions, those decisions take precedence over the Advance Directive. For more information about Advance Directives, check with a doctor, attorney, Hospital, nursing home, local Council on Aging, or the Massachusetts Department on Aging for information. A health proxy form, used to appoint a Health Care Agent, can be requested by writing and sending self-addressed, stamped envelope to:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Room 517
Boston, MA 02108

Organ Donations

You may also document your wishes regarding organ and tissue donation by completing an organ donor card. For more information about organ/tissue donation, contact:

The New England Organ Bank
One Gateway Center
Newton, MA 02158-2803
(800) 446-NEOB or (800) 446-6362

N. Pharmaceutical Coverage Exclusions

NHP's prescription drug benefit features an open Preferred Drug List, in which the following drugs are excluded:

- Dietary supplements.[1]
- Therapeutic devices or appliances (except where noted).[1]
- Biologicals, immunization agents or vaccines.[2]
- Blood or blood plasma.[2]
- Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, nursing home, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.[2]
- Charges for the administration or injection of any drug.[2]
- If an FDA approved generic drug is available, the brand name equivalent is not covered.
- Anabolic steroids.
- Chlorzoxazone.
- Nicotrol NS.
- Progesterone supplements.
- Fluoride supplements/vitamins over age 13.
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medications for which the cost is recoverable under Worker's Compensation or Occupational Disease Law or any state or Governmental Agency, or medication furnished by any other Drug or Medical service for which no charge is made to the Member.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

1. Covered in certain circumstances under medical benefit
2. Covered in certain circumstances under the Durable Medical Equipment (DME) benefit.

For more information about NHP's Preferred Drug List call Member Services at 1-800-462-5449, TTY 1-800-655-1761 or visit our web site at www.nhp.org.

O. Member Complaints & Grievances

NHP tries to meet and go beyond what our Members expect of us. If an NHP experience did not meet with your expectations, we want to know about it so we can understand your needs and provide better service.

Complaints

Members have the right to voice concerns and file Complaints. If you file a Complaint, NHP staff will be courteous and professional, and all information will be kept private and confidential. Filing a Complaint will not affect your NHP coverage in a negative way. To file a Complaint, call NHP Member Services at 1-800-462-5449 (TTY 1-800-655-1761). NHP is located at 253 Summer Street, Boston, MA 02210.

Representatives are here to assist you Monday through Friday, 8:30 A.M. to 6:00 P.M. When you call, a Member Services representative will ask for information about the Complaint, and, if possible, solve the problem over the telephone at the time of your call. If the Member Services Representative cannot resolve the situation to your satisfaction at the time of your call, we will make every effort to resolve your Complaint within three (3) business days (Internal Inquiry Period). If we are unable to satisfactorily resolve your Complaint within three (3) business days, we will, at your request, continue to investigate and resolve the matter through our internal grievance process.

Grievances

If you are not satisfied with the way NHP responded to your Complaint or with any decision made by NHP about your health care or service, you have the right to file a grievance. A grievance is a request that NHP reconsider a decision or investigate a complaint regarding the quality of care or services that you have received or any aspect of NHP's administrative operations. If your grievance is about a decision NHP has made to deny coverage of health care or services, you must file your grievance within 180 calendar days of your being notified of the decision. Filing a grievance will not affect your NHP coverage in a negative way. The time period for NHP to resolve your grievance will begin either on the day after the Internal Inquiry Period, or at any time during the Internal Inquiry Period if you notify NHP that you are not satisfied with the response thus far to your inquiry. Time limits may only be waived or extended by mutual written agreement between you or an authorized representative and NHP. Any such agreement shall state the additional time limits, which shall not exceed fifteen (15) business days from the date of the agreement. You may designate an authorized representative (a friend, relative, healthcare Provider, etc.) to act as your representative during the grievance process. The authorized representative has the same rights and responsibilities as the Member.

O. Member Complaints and Grievances

Frequently Asked Questions about the Grievance Process

How do I file a grievance?

You may file a grievance by telephone, in person, by mail or by fax. NHP will send you a written acknowledgement of receipt of your grievance within five (5) business days. If you telephone us, or stop by in person, your grievance will be transcribed by NHP and a copy forwarded to you or your authorized representative within forty-eight (48) hours (except where this time limit is waived or extended by mutual written agreement between you or your authorized representative and NHP). We request that you read, sign and return to NHP this written transcription of your oral complaint. This helps to ensure that we fully understand the nature of your complaint. You may contact NHP in writing or by phone:

Neighborhood Health Plan	*Phone Numbers*
Attn: Member Services Dept. 253 Summer Street Boston, MA 02210-1120	1-800-462-5449 TTY 1-800-655-1761

What if my grievance is about my health care or services?

If your grievance pertains to a decision NHP has made about your health care or services, you or your authorized representative will be asked to sign a form authorizing the release of medical information relating to your grievance to NHP. After receipt of the releases, your medical information will be requested by NHP. You or your authorized representative will have access to any medical information and records relevant to the grievance which are in the possession of NHP. If you (or your authorized representative) do not provide the signed authorization for release of medical information within thirty (30) business days of the receipt of the grievance, NHP, or its Utilization Review Organization may issue a resolution of the grievance without review of some or all of the medical records. In cases regarding behavioral health or substance abuse services, NHP has delegated the grievance management to Beacon Health Strategies. If preferred, Members may always bring their grievance to Neighborhood Health Plan.

What if resolution does not require review of my medical records?

If resolution of your grievance does not require review of your medical records, the grievance resolution process will begin on the day immediately after the Internal Inquiry Period or sooner if you notify NHP that you are not satisfied with NHP's response during the Internal Inquiry Period.

Who will review my grievance?

Grievances are reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance. Grievances of Adverse Determinations

will be reviewed by an individual or individuals that *did not* participate in any of the prior decisions regarding the matter of the grievance. These individuals are actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure, or provide the treatment that is the subject of the grievance.

How will I be informed of NHP's decision on my grievance?

NHP will send you a written decision on your grievance which will include complete identification of the specific information considered and an explanation of the basis for the decision. In the case of a grievance that involves Adverse Determination, the written resolution will include a substantive clinical justification consistent with generally accepted principles of medical practice, and will, at a *minimum:*

- **Identify the specific information upon which the adverse determination was based;**
- **Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria;**
- **Specify alternative treatment options NHP covers, if any;**
- **Reference and include applicable clinical practice guidelines and review criteria; and**
- **Notify you (or your authorized representative) of the procedures for requesting external review.**

When will I hear from NHP about my grievance?

NHP will contact you in writing within thirty (30) business days with the outcome of your grievance review, unless you and NHP agreed to an extension. If NHP does not act upon your grievance within thirty (30) business days or the agreed upon extended time frame, the grievance will be decided in your favor. Any extension deemed necessary to complete the review of your grievance must be authorized by mutual written agreement between you or your authorized representative and NHP.

More Important Information
about your Grievance Rights

Continuation of Services during the Grievance Process

If the subject matter of the grievance involves the termination of ongoing services, the disputed coverage or treatment will remain in effect without liability to you until you or the your authorized representative have been informed of NHP's decision. This

continuation of coverage or treatment applies only to those services which, at the time of their initiation, were approved by NHP and which were not terminated pursuant to an exhaustion of your benefit coverage.

Reconsideration

NHP may offer you (or your authorized representative) the opportunity for reconsideration of a final Adverse Determination where relevant medical information was:

- **Received too late to review within the thirty (30) business-day time limit; or**
- **Not received, but is expected to become available within a reasonable time period following the written resolution.**

If you choose to request reconsideration, NHP or its Utilization Review organization must agree in writing to a new time period for review, but in no event greater than thirty (30) business days from the agreement to reconsider the grievance. The time period for requesting external review will begin on the date of the resolution of the reconsidered grievance.

Expedited Grievance Review for Special Circumstances

If you or your doctor believe your health, life, or ability to regain maximum functioning may be put at risk by waiting thirty (30) business days, you or your doctor can request an expedited grievance review. An expedited grievance may be requested if NHP denies coverage for:

1. **Continued Hospital care**
2. **Any services that a physician certifies are required to prevent serious harm, and**
3. **Any services to a Member with a terminal illness.**

NHP will inform you of the outcome of the Expedited Grievance Review in writing within three (3) calendar days of receiving the request. Furthermore:

> *Written resolution of the expedited grievance will be made before discharge from a Hospital if you or your authorized representative submit the grievance while you are in the Hospital. NHP will automatically reverse decisions denying coverage for services or Durable Medical Equipment (DME), pending the outcome of the internal grievance process, within forty-eight (48) hours (or earlier for Durable Medical Equipment (DME) at the option of a physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said physician that, in the physician's opinion:*

1. **The service or use of Durable Medical Equipment (DME) at issue in a grievance is Medically Necessary;**
2. **A denial of coverage for such services or Durable Medical Equipment would create a substantial risk of serious harm to the patient, and;**
3. **Such risk of serious harm is so immediate that the provision of such services or Durable Medical Equipment (DME) should not await the outcome of the normal grievance process.**
4. **In the event a physician exercises the option of automatic reversal earlier than forty-eight (48) hours for durable medical equipment, the physician must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the forty-eight (48) hour time period. Your doctor may contact NHP Clinical Operations at 1-617-772-5500 with questions about this procedure.**

Expedited Grievance Review for Persons with Terminal Illness

When a grievance is submitted by an insured with a terminal illness, or by the insured's authorized representative on behalf of said insured, resolution will be provided to the insured or said authorized representative within five (5) business days from the receipt of the grievance. If the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will provide the insured or the insured's authorized representative, within five (5) business days of the decision:

- **A statement, setting forth the specific medical and scientific reasons for denying coverage or treatment;**
- **A description of alternative treatment, services or supplies covered or provided by NHP, if any.**

In addition, if the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will allow the insured, or the insured's authorized representative, to request a conference. The conference will be scheduled within ten (10) days of receiving a request from an insured; provided however that the conference shall be held within five (5) business days of the request if the treating physician determines, after consultation with NHP's medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by NHP, would be materially reduced if not provided at the earliest possible date.

At the conference, NHP will permit attendance of the insured, the authorized representatives of the insured, or both. A representative of NHP, who has authority to determine the disposition of the grievance, shall review the information provided to the insured.

Independent External Review

If you are not satisfied with the final outcome of the grievance review you receive, you have the right to apply for an independent external review with the Massachusetts Department of Public Health's Office of Patient Protection. The Office of Patient Protection provides an independent review of grievances not resolved at the health plan (NHP) level to your satisfaction. The External Review Panel will review if the service or treatment in question is Medically Necessary and is a covered benefit.

You, or your authorized representative, are responsible to activate the External Review Process. To activate the review, contact NHP to obtain a copy of the External Review Application:

- **Complete and submit the required application to the Department of Public Health within forty-five (45) days of the receipt of NHP's Final Grievance decision;**
- **Submit applicable filing fees ($25.00) to the Department of Public Health (The Office of Patient Protection may waive the fee in cases of extreme financial hardship).**

You may contact the Office of Patient Protection at any time by telephone at (800) 436-7757, by fax (617) 624-5046, or on the internet at www.state.ma.us/dph/bhqm. The decisions of the External Review Process are final and binding.

Expedited External Review and Continuation of Coverage

You or your authorized representative may request to have your request for review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from your physician, that delay in the providing or continuation of health care services that are the subject of a final Adverse Determination would pose a serious and immediate threat to your health. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made by the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result in the absence of such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at NHP's expense regardless of the final external review determination.

O. Member Complaints and Grievances

For more information about your grievance rights as a resident of the Commonwealth of Massachusetts, contact the Massachusetts Office of Patient Protection. You can contact the Office of Patient Protection (OPP) at any time by telephone at (800) 436-7757, by fax (617) 624-5046, or on the internet at www.state.ma.us/dph/bhqm. The following information is available to you from the OPP:

- **A list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of Covered Health Care Services offered by NHP;**
- **The percentage of physicians who voluntarily and involuntarily terminated participation contracts with NHP during the previous contract year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;**
- **The percentage of premium revenue expended by NHP for health care services provided to Insureds for the most recent year for which information is available;**
- **A report detailing, for the previous contract year, the total number of filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and, external Appeals pursued after exhausting the internal grievance process and the resolution of all such external Appeals.**

IMORTANT NOTICE

All information in this Evidence of Coverage pertaining to complaints and grievances applies to all medical care, treatment or services, as well as all mental health care, treatment or services.

P. Glossary (Definitions)

Activities of Daily Living (ADL)

The normal functions of daily life, including walking, speaking, sleeping, eating, drinking, and using the toilet.

Acute Care Hospital

A licensed facility that is under contract with or approved by NHP to provide treatment of the sick and injured (acute medical care) to NHP Members. Admission to an Acute Hospital requires a Referral by the Member's Primary Care Provider and authorization by NHP. The only exceptions are in a life threatening Emergency and for care out of the NHP Service Area.

Advance Directive

A written statement that tells a Provider what to do if an illness or accident takes away the Member's ability to make decisions about his or her health care.

Adverse Determination

A determination, based upon a review of information provided, by NHP or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Agreement

This legal document, including all appendices, which defines the relationship between Members and NHP.

Alternative Mental Health/Substance Abuse Services

Mental health/substance abuse services provided as an alternative to Hospitalization.

Ambulance Service

Professional Ambulance Services when approved by an NHP physician or NHP nurse to transport a patient to or from a Hospital or any other required destination as an inpatient or outpatient.

Ambulatory / Day Surgery

Any Outpatient surgical procedure performed in a Hospital operating room under anesthesia that does not require an overnight stay in the Hospital. Services may also be provided in a freestanding Ambulatory Surgical facility.

Anniversary Date

The date agreed to by NHP and the Group Insurance Commission upon which changes in the Group Contract become effective.

P. Glossary

Appeal

A formal request, initiated by a Member or a Member's representative, that NHP reconsider a decision on Coverage of benefits.

Arbitration

A process by which the meaning of the Evidence of Coverage is determined by a third party.

Beacon Health Strategies

The organization contracted by NHP to work in collaboration with the NHP Mental Health Department to administer NHP's Mental Health/Substance Abuse Program.

Benefit Handbook (Member Handbook)

A Handbook for Members of NHP that provides information about benefits, policies, procedures, Covered Health Care Services, and how to contact NHP.

Capitation

A stipulated dollar amount established to cover the cost of health care delivered for a person. Capitation is paid to NHP participating Primary Care Provider groups on a monthly basis.

Carrier

Another term for an insurance provider, such as an HMO, a liability insurance provider, or private insurer.

Claim

An invoice from a Provider that describes the services that have been provided for a Member with a request for payment.

Complaint

A statement by a Member of dissatisfaction with care or services received.

Contract Year

The period of time covered by the Group Contract.

Contracted Provider

See "NHP Provider" in this section.

Coordination of Benefits

A process by which it is determined how Health Care Services will be paid when an individual is covered by more than one health plan. COB is used to eliminate over insurance or duplication of benefits.

P. Glossary

Copayment

That portion of the charge, if any, for a Covered Health Care Service that a Member is obligated to pay according to the Agreement between the Group Insurance Commission and NHP. The Provider of the service will collect the Copayment from the Member at the time of the Member's visit.

Copayment Card/Benefit Summary

The Benefit Summar (also called a Copayment Card) is a general description of your NHP coverage. It also lists the Copayment amount, if any, on services your GIC policy covers. The Benefit Summary is not the same as a Member Identification Card (see Member Identification Card in this section).

Covered Health Care Services

The medical and behavioral health care services for which a Member is eligible under this Evidence of Coverage. Except as specifically stated in this Evidence of Coverage, only services and supplies that are Medically Necessary and provided or authorized by a Member's Primary Care Provider or Beacon Health Strategies behavioral health care provider or the clinicians he or she designates are Covered Health Care Services.

Covered Health Care Services are defined as at least reasonably comprehensive Inpatient, Outpatient, and Emergency care services including: preventive services, such as immunizations; periodic health exams for adults; well child care including vision and auditory screening; Family Planning; nutrition counseling and health education; pediatric care; a minimum of 100 days in a calendar year or 365 lifetime days of noncustodial care in a Skilled Nursing Facility; and which may include, but are not limited to, preventive care, optometric services, podiatric services and behavioral health services.

Date of Service

The date a Covered Health Care Service is received.

Dependent

An individual who obtains health coverage through a Subscriber, such as a Subscriber's spouse or child, including newborn infants and newborn infants of a Dependent from the moment of birth and adopted children from the date of placement in the home, or, if a foster child, from the date of the filing of the petition to adopt. (See Section E, Eligibility and Enrollment).

Durable Medical Equipment (DME)

Equipment that can stand repeated use, is primarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

P. Glossary

Effective Date

The date when Coverage under this contract or under an amendment to it, becomes available to Members.

Emergency

An Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment of body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, placing the insured or her unborn child's physical or mental health in serious jeopardy. With respect to a pregnant woman who is having contractions, an Emergency also includes having an inadequate time to effect a safe transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in the event of transfer to another hospital before delivery.

Employer Group

The Group Insurance Commission, the state agency with which NHP enters into an Agreement to provide health care Coverage for the GIC's eligible employees and their Dependents.

Enrollment

The process by which NHP registers individuals for membership.

Enrollment Area

See "NHP Service Area" in this section.

Expedited Review

A 72-hour Appeals process.

Family Plan Coverage

Coverage for a Subscriber and one or more family Dependents.

Family Planning Services

Services directly related to the prevention of conception. Services include:

- **Birth control counseling and family planning;**
- **Examination, treatment and lab exams/tests for all medically approved methods and procedures;**
- **Pharmacy supplies and devices; and**
- **Sterilization, including tubal ligation and vasectomy.**

Abortion is not a Family Planning Service (see Section F. Covered Health Care Services, or contact Neighborhood Health Plan for more information).

P. Glossary

Group Insurance Commission Contract

The Contract between the Group Insurance Commission and NHP that sets forth the obligations of the GIC and the terms of NHP coverage for GIC insureds.

Handbook

See "Benefit Handbook" in this section.

Health Care Agent

The individual responsible for making health care decisions for a person in the event of that person's incapacitation.

Health Maintenance Organization (HMO)

An organization that provides, offers or arranges for Covered Health Care Services that emphasize preventive care. HMOs use a Network of Primary Care Providers, doctors, and other Providers to deliver services.

Home Health Services

Medically Necessary Services of a physician, registered nurse or home care agency, provided that such services are rendered within the Service Area and authorized by the Member's PCP.

Hospital

Any institution or facility so designated by the Plan, including a chronic disease Hospital, subject to the conditions, limitations and exclusions contained in this contract.

Individual Coverage

Coverage for a Subscriber only.

Inpatient Services

Services requiring at least one overnight stay. Inpatient Services generally apply to services rendered in facilities such as Hospitals and skilled nursing facilities.

Insured

A person covered under a health insurance policy.

Licensed Mental Health Professional

Includes a licensed physician who specialized in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

P. Glossary

Managed Care

A system of health care delivery that is provided and coordinated by a Primary Care Provider. The goal is a system that delivers value by providing access to quality, cost-effective health care.

Maternity Services

Maternity Services are defined as the services of:

- A physician or other authorized NHP professional for the delivery of one (1) or more than (1) fetus and includes delivery by Caesarean section or other surgical intervention, prenatal and postnatal care, false labor, circumcision, care of the newborn during confinement, and all Medically Necessary Services due to conception or subsequent growth of a fetus.
- A Hospital for the routine care of the mother and newborn child during confinement for the delivery of one (1) or more than one (1) fetus including delivery by Caesarean section or other surgical intervention, admission for false labor and circumcision, and all Medically Necessary Services due to the conception or subsequent grown of a fetus.

Medically Necessary Services

Medically Necessary means Health Care Services that are consistent with generally accepted principles of professional medical practice as determined by whether:

1. The service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harms to the individual;
2. Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
3. Complies with the standards of good medical practice; or
4. Are not primarily for the convenience of the Member; or
5. For services and interventions not in widespread use is based on scientific evidence.

Member

Any individual enrolled in NHP and covered by this Agreement.

Member Identification Card (ID Card)

The card that identifies an individual as a Member of NHP. The Member Identification Card includes the Member's identification number, Primary Care Site, and information about the Member's coverage. The Card must be shown to Providers prior to receipt of services.

P. Glossary

Member Handbook

See "Benefit Handbook" in this section.

Member Services Department

A department within NHP that handles all Member communication regarding benefits, policies, procedures, requests and concerns. A representative can be reached by calling 1-800-462-5449 or TTY 1-800-655-1761 between the hours of 8:30 A.M. and 6:00 P.M.

Mental Health Services

The diagnosis and treatment of a psychiatric condition which is judged by an NHP licensed and approved Mental Health Provider to be appropriate for psycho-therapeutic treatment. Benefits also include services for diagnosis and treatment of substance abuse problems.

Neighborhood Health Plan or NHP

A Massachusetts licensed Health Maintenance Organization (HMO) that provides health care benefits to its Members through Participating Providers.

Network

The group of Providers contracted by NHP to provide Covered Health Care Services to Members.

NHP Fee Schedule

A listing of medical services with pre-established payment amounts. When NHP Participating Providers submit Claims for non-primary care services, they are paid according to the NHP Fee Schedule.

NHP Hospital

A Hospital that has an agreement with NHP to provide certain Covered Services to Members. NHP Hospitals are independently contracted.

NHP Participating Pharmacy

A pharmacy contracted with NHP. Participating Pharmacies include all major chains (CVS, Walgreens, Brooks, etc.) and most community pharmacies.

NHP Participating Provider or Participating Provider

A health care facility under contract with or approved by NHP; a licensed health care professional who is under contract with, or approved by NHP; or a licensed heath care professional who is employed by or otherwise affiliated with an organization that has a contract with or it approved by NHP to provide Covered Health Care Service to Members with an expectation of receiving payment other than coinsurance, Copayments, or deductibles directly or indirectly from NHP.

P. Glossary

NHP Service Area

NHP's Service Area is the geographical area within which NHP has developed a Network of Providers to provide adequate access to Covered Services

County	Area
Bristol	Acushnet, Dartmouth, Easton, Fairhaven, and New Bedford.
Essex	Entire County
Hampden	Entire County
Middlesex	Entire County
Norfolk	Entire County
Plymouth	Abington, Bridgewater, Brockton, East Bridgewater, Hanover, Hingham, Hull, Marshfield, Mattapoisett, Norwell, Rochester, Rockland, Scituate, West Bridgewater and Whitman.
Suffolk	Entire County
Worcester	Entire County

Because NHP Service Areas change periodically, it is important that you check the availability of Providers in your area to verify they are part of the NHP Provider Network.***** For information about Providers in your area, refer to your NHP Provider Directory, the NHP website at www.nhp.org, or call Member Services at 1-800-462-5449 (TTY 1-800-655-1761).

*If you need Emergency care or Urgent Care while you are temporarily outside the NHP Service Area, go to the nearest doctor or Emergency Room or call 911.

Non-Contracted Provider (or Non-Participating)

See "Out-of-Network Provider" in this section.

Occupational Therapy

Evaluation of and treatment for impaired physical functions.

Out-of-Network Provider

Providers not contracted with NHP.

Outpatient Services

Services provided in a doctor's office; a Day Surgery or Ambulatory care unit; an Emergency Room or outpatient clinic; or another location. Outpatient Services include all services that are not Inpatient Services.

Palliative Care

Care intended to relieve or soothe the symptoms of a disease or disorder without effecting a cure. Palliative care may be a component of both short-term and long-term care; hospice or end-of-life care; or other clinical treatment or service.

P. Glossary

Physical Therapy

Evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems.

Primary Care Provider (PCP)

A doctor, or any primary care clinician acting on behalf of and in consultation with a Primary Care Provider. Primary Care Providers include, but are not limited to, physicians, registered nurses, nurse practitioners, physician's assistants, and nurse midwives.

Primary Care Site

The locations where Primary Care Providers provide care to NHP Members. A Primary Care Site may be a Health Center, an Outpatient department of a Hospital, a physician group practice, or another setting.

Provider

A health care professional or facility licensed as required by state law. Providers include doctors, Hospitals, laboratories, pharmacies, skilled nursing facilities, nurse practitioners, registered nurses, psychiatrists, social workers, licensed mental health counselors, clinical specialists in psychiatric and mental health nursing, and others. NHP will only cover services of a Provider if those services are Covered Health Care Services and within the scope of the Provider's license.

Provider Directory

A book containing a list of NHP's affiliated medical facilities and professionals, including Primary Care Providers and Specialists.

Psychiatric Hospital

A licensed facility for the diagnosis and treatment of mental illness which is under contract with or approved by NHP or its mental health subcontractor to provide psychiatric care to NHP Members.

Psychopharmacology

The use of medications to treat mental health and substance abuse problems.

Rehabilitation Hospital

A facility licensed to provide therapeutic services to help restore function after an illness or injury. Services provided include Occupational, Physical, and Speech Therapy; and skilled nursing.

Referral

A recommendation by a Primary Care Provider for a Member to receive care from a different Provider, such as a Specialist.

P. Glossary

Routine Mental Health and Substance Abuse Services
Outpatient and Alternative mental health/substance abuse services.

Skilled Nursing Facility
An Inpatient facility which provides skilled nursing to Members who no longer require the services of an acute care Hospital.

Specialist
A doctor who is trained to provide specialty services. Examples include cardiologists, obstetricians and dermatologists.

Speech Language Therapy
Evaluation and treatment of speech language, voice, hearing, and fluency disorders.

Subrogation
The procedure under which NHP can recover from third parties the full or partial cost of benefits paid.

Subscriber
The person who signs an application on behalf of himself or herself and any Dependents for Enrollment in NHP.

Utilization Review
A set of formal review techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficiency of, Covered Health Care Services, procedures, or settings. Such review techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization Review Organization
An entity that conducts Utilization Review under contract with or on behalf of NHP.

Urgent Care
Urgent Care is medical care required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life threatening and do not pose a risk of permanent damage to a Member's health. Urgent Care does not include care that is elective, Emergency, preventive or health maintenance. Examples of conditions requiring Urgent Care include, but are not limited to, fever, sore throat, earache, acute pain.

Workers' Compensation
Insurance Coverage maintained by employers under federal law to cover employees' injuries and illnesses under certain conditions.

Q. Provider Compensation

Professional Services are compensated through arrangements that range from Capitation to Fee-for-Service. All NHP-affiliated Hospitals are paid based on individually negotiated contracts.